

## CHAPTER 3

### PHYSICAL STANDARDS AND EXAMINATION

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## CHAPTER THREE – PHYSICAL STANDARDS AND EXAMINATION

### A. Administrative Procedures.

1. Applicability of Physical Standards.
  - a. CG Standards. The provisions of this chapter apply to all personnel of the CG and CG Reserve on active or inactive duty and to commissioned officers of the U.S. Public Health Service assigned to active duty with the CG.
  - b. Armed Forces Standards. Members of the other Armed Forces assigned to the CG for duty are governed by the applicable instructions of their parent Service for examination standards and for administrative purposes.
2. Prescribing of Physical Standards. Individuals to be enlisted, appointed, or commissioned in the CG or CG Reserve must conform to the physical standards prescribed by the Commandant. Separate standards are prescribed for various programs within the Service. All CG members are required to be medically ready for deployment. All Individual Medical Readiness (IMR) requirements, as delineated in the Coast Guard Periodic Health Assessment (PHA), COMDTINST M6150.3, are required to be met by CG AD and SELRES members (to include Direct Commission Officers at point of accession). The CG clinic affiliated with the point of accession is responsible for inputting the IMR data into the applicable medical information system (MIS) database (i.e. Medical Readiness Reporting System (MRRS), etc.).
3. Purpose of Physical Standards. Physical standards are established for uniformity in procuring and retaining personnel who are physically fit and emotionally adaptable to military life. These standards are subject to change at the Commandant's direction when the needs of the CG dictate.
4. Application of Physical Standards.
  - a. Conformance with Physical Standards Mandatory. To determine physical fitness, the applicant or member shall be physically examined and required to meet the physical standards prescribed in this chapter for the program or specialty and grade or rate involved. An examinee who does not meet the standards shall be disqualified.
  - b. Evaluation of Physical Fitness. The applicant's total physical fitness shall be carefully considered in relation to the character of the duties to that the individual may be called upon to perform. Physical profiling is not a CG policy. Members shall be considered fit for unrestricted worldwide duty when declared physically qualified. The examiner must be aware of the different physical standards for various programs. Care shall be taken to ensure an examinee is not disqualified for minor deviations that are clearly of no future significance with regard to general health, ability to serve, or to cause premature retirement for physical disability. However, conditions that are

likely to cause future disability or preclude completing a military career of at least twenty years, whether by natural progression or by recurrences, are also disqualifying. This policy shall be followed when an authentic history of such a condition is established, even though clinical signs may not be evident during the physical examination or periodic health assessment (PHA).

5. Interpretation of Physical Standards. Examiners are expected to use discretion in evaluating the degree of severity of any defect or disability. They are not authorized to disregard defects or disabilities that are disqualifying in accordance with the standards found in this Chapter.
6. Definitions of Terms Used in this Chapter.
  - a. Officers. The term "officers" includes commissioned officers, warrant officers, and commissioned officers of the U.S. Public Health Service (USPHS).
  - b. Personnel. The term "personnel" includes members of the CG and CG Reserve, and the USPHS on AD with the CG.
  - c. Medical and Dental Examiners. Medical and dental examiners are medical and dental officers of the uniformed services, contract physicians and dentists, or civilian physicians or dentists who have been specifically authorized to provide professional services to the CG. Some USMTFs have qualified enlisted examiners who also conduct medical examinations and their findings require countersignature by a Medical Officer.
  - d. Flight Surgeons, Aviation Medical Officers and Aeromedical Physician Assistants. Officers of a uniformed service who have been so designated because of special training.
  - e. Command/Unit. For administrative action required on the Report of Medical Examination, Form DD-2808 the command/unit level is the unit performing personnel accounting services for the individual being physically examined.
  - f. Reviewing/Approving Authority. Commander, Personnel Service Center (PSC-de) and HSWL SC are responsible for approval of physical examinations as outlined herein. Health Services Administrators may act as reviewing and/or approving authority for physical examinations performed in their AOR, including those performed by contract physicians and USMTF's as designated by HSWL SC, except for those that are aviation or dive related. Health Services Administrators may request physical examination review/approval authority for Clinic Supervisors assigned to their clinic from HSWL SC. Reviewing authority shall not be delegated below the HSC level. Upon approval or disapproval of the physical examination, an entry in the comments block of the Medical Readiness and Reporting System (MRRS) will be made stating where the physical was approved or disapproved and the reason for disapproval, if applicable. Health Services Administrators may

review physical examinations performed by contract physicians and USMTFs within their AOR.

- g. Convening Authority. Convening Authority is an individual authorized to convene a medical board as outlined in Physical Disability Evaluation System, COMDTINST M1850.2 (series).
  - h. Time Limitation. The time limitation is the period for which the physical examination or assessment remains valid to accomplish its required purpose. The time limitation period begins as of the day after the physical examination or assessment is conducted.
7. Required Physical Examinations & Assessments and Their Time Limitations.
- a. Enlistment. A physical examination is required for original enlistment in the CG and the CG Reserve. This physical examination will usually be performed by Military Entrance Processing Stations (MEPS) and is valid for twenty-four months. Approved MEPS physicals do not require further review. Recommendations noted on separation physical examinations from other services must have been resolved with an indication that the individual meets the standards. A certified copy of that physical examination must be reviewed and endorsed by the reviewing authority CG Recruiting Command (CGRC). The reviewing authority must indicate that the applicant meets the physical standards for enlistment in the USCG.
    - (1) Recruiters who believe that applicants have been erroneously physically disqualified by MEPS, may submit the Report of Medical Examination, Form DD-2808 and Report of Medical History, Form DD-2807-1 (original or clean copies) along with supporting medical documentation to Commander (CGRC) for review.
    - (2) Waiver of physical standards for original enlistment may also be submitted as above, and in accordance with paragraph 3-A-8 of this Chapter.
    - (3) Separation physical examinations from any Armed Service may be used for enlistment in the CG provided the examination has been performed within the last twelve (12) months. The physical examination must be as complete as a MEPS exam, include an HIV antibody test date (within the last 24 months) and result, and a Type II dental examination. A Report of Medical History, Form DD-2807-1 must also be included with elaboration of positive medical history in the remarks section (item #25). Forward all documents for review to Commander (CGRC).
    - (4) Prior Service enlisted aviation personnel must obtain an aviation physical examination from a currently qualified Uniformed Services Flight Surgeon or AMO within the previous 12 months. This physical examination will be submitted with the rate determination package to Commander (CGRC).



- (5) Occasionally, applicants for initial entry into the Coast Guard will need to be examined at CG MTFs. In these cases, the physical examination will be performed per section 3-C. The examining Medical Officer may defer item #46 of the Report of Medical Examination, Form DD-2808 to the Reviewing Authority. Otherwise, the physical standards for entry (sections 3-D and 3-E of this Manual, and relevant sections of the Aviation Medical Manual, COMDTINST M6410.3 (series)) must be meticulously applied when completing this item. The completed Report of Medical Examination, Form DD-2808 and Report of Medical History, Form DD-2807-1 will be forwarded to the reviewing authority, Commander (CGRC).
- b. Pre-Commissioning/Appointments Examination. A physical examination is required within 12 months prior to original appointment as an officer in the CG or CG Reserve for personnel in the following categories:
  - (1) Appointments to Warrant Grade, except that physical examinations for members of the CG Ready Reserve must be within 24 months prior to the date of execution of the Acceptance and Oath of Office, Form CG-9556.
  - (2) Appointment of a Direct Commission Officer, prior to the date of execution of the Acceptance and Oath of Office.
  - (3) Appointment of a Licensed Officer of the U. S. Merchant Marine as a commissioned officer (examination required within 6 months).
  - (4) Graduates of the CG Academy and Officer Candidates School, prior to the execution of the Acceptance and Oath of Office.
- c. Separation or Retirement Examination.
  - (1) These examinations shall be used for Reserve members (on active duty orders for greater than 30 days) and AD members who are leaving the Coast Guard, retiring, or not planning on rejoining a military service. These examinations may be used by Reserve members (on active orders for 30 days or less) who are separating or retiring from the Ready Reserve (SELRES or IRR). Separation or retirement examinations are optional for reserve members on orders for 30 days or less.
  - (2) The separation or retirement examination consists of the Report of Medical Examination, Form DD-2808 and Report of Medical History, Form DD-2807. Objections to assumption of fitness at separation or retirement are addressed in the Physical Disability Evaluation System, COMDTINST M1850.2 (series). There is no requirement to document separation or retirement examinations in the current medical readiness tracking system (e.g., MRRS).
  - (3) The medical examination must include: notation of any current problems, a blood pressure measurement, and address items on the preventive



medicine stamp. In addition to the above, the practitioner shall ascertain the health needs of the member and undertake measures deemed necessary to meet those needs. The dental examination, if requested, must at least be a Type III exam. These examinations may be annotated on a Chronological Record of Medical Care, Form SF-600, and upon completion, do not require approval.

- d. Periodic Health Assessment. All AD and Reserve personnel must have an annual PHA during their birth month period in accordance with Coast Guard Periodic Health Assessment, COMDTINST M6150.3 (series). For the purpose of this Instruction, a member's birth month period is defined as the actual month of birth and the preceding two (2) months. The PHA is a multi-component process that will ensure CG members are ready for deployment, ensure individual medical readiness (IMR) data is electronically recorded, and deliver evidence-based clinical preventive services. The PHA will address prevention of disease and injury by focusing on prevention strategies each member can incorporate into his/her lifestyle. The PHA has replaced the routine five year (quinquennial) physical examination. Specialty examinations Department of Defense Medical Examination Review Board (DODMERB), Military Entrance Processing Station (MEPS), commissioning, appointment to Chief Warrant Officer (CWO), enlistment, retirement, confinement, aviation, landing signal officer (LSO), dive, and Medical Evaluation Board (MEB) will still be required.
- e. Medical Evaluations. A completed PHA and Report of Medical Assessment, Form DD-2697, shall be used in four scenarios described below. CG members in these four scenarios are authorized to complete their evaluations at CG clinics. CG Medical Officers shall clearly annotate in Block 20 of the Report of Medical Assessment, Form DD-2697 whether the member meets retention standards in accordance with Chapter 3 F of this Manual. There is no requirement to document the PHA and Report of Medical Assessment, Form DD-2697 in the current medical readiness tracking system (e.g, MRRS) if used in the four scenarios documented below. However, the PHA can be used as the member's current PHA if it's completed within the member's birth month period (which will be documented in the current medical readiness tracking system (e.g, MRRS). The four scenarios in which the PHA and Report of Medical Assessment, Form DD-2697 shall be used in conjunction are:
  - (1) Reserve members who are being released from active duty orders (greater than 30 days) [A new PHA must be completed within 10 days from being released from active duty orders. For members deployed outside of the United States, the PHA should be completed upon return to the United States.].
  - (2) IRR members who are changing status to the SELRES or AD (IRR members must be on orders using one Readiness Management Period

(RMP) in order to complete their evaluation at a CG clinic. IRR members need to contact the In Service Transfer Team (ISTT) at (703) 235-1731. The ISTT will verify that the member is looking to come out of the IRR and will need a medical evaluation (PHA and Report of Medical Assessment, Form DD-2697). The ISTT will contact the CG Personnel Service Command Reserve Personnel Management (PSC-RPM-3). PSC-RPM-3 will issue RMP orders to IRR members once the member has received a date and location for an evaluation.

(3) AD members changing status to the Ready Reserve (SELRES or IRR)

(4) Retired members being recalled to AD or Reserve duty

f. Overseas Transfer, Sea Duty and Port Security Unit (PSU) Assignment, Screening.

(1) To help identify and resolve health related issues prior to transfer a modified physical screening utilizing the Modified Screening For Overseas Assignment and/or Sea Duty Health Screening, Form CG-6100 is required for all personnel if one of the following apply:

(a) PCS transfer to vessel with a deployment schedule of 60 consecutive days or more (out of 365).

(b) PCS transfer to an overseas assignment. (e.g., Alaska, Hawaii or Puerto Rico)

(c) Transferring from one overseas assignment to another overseas assignment.

(d) PSU personnel (Must be done annually).

(2) The Modified Screening For Overseas Assignment and/or Sea Duty Health Screening, Form CG-6100 must be completed as follows: Section B must be completed and signed by the patient. Section C thru E must be completed and signed by a civilian, DOD or CG medical or dental provider, or CG IDHS. Any responses of medical or dental significance requiring further clarification or evaluation need to be reviewed by either a civilian, DOD or CG medical or dental provider. Section F must be completed and signed by the cognizant Health Services Administrator (if a warrant officer, otherwise the screening must be signed by HSWL SC) for final approval or disapproval. The Modified Screening For Overseas Assignment and/or Sea Duty Health Screening, Form CG-6100 must be placed in section 1 of the health record. The modified physical screening will include the following:

(a) A health history completed by the evaluatee. (The evaluatee will certify by signature that all responses are true).

- (b) Documentation of the current PHA to include the status of recommendations and summary of significant health changes.
  - (c) Review of the health record to ensure routine health maintenance items are up-to-date to include:
    - [1] Routine gynecologic examinations.
    - [2] Two pairs of glasses and gas mask inserts for PSU personnel if required to correct refractive error, DNA sampling, G-6-PD screening, immunizations, HIV testing and a Type 2 dental examination.
  - (d) Review malaria chemoprophylaxis, TST and special health concern requirements. Contact the Center for Disease Control and Prevention (CDC) at <http://www.cdc.gov> or <http://www.travel.state.gov> for information. Questions regarding the appropriate preventive medical measures should be referred to Commandant (CG-1121).
  - (e) If PCS transferring to a foreign country, HIV antibody test must have been conducted within the past 6 months with results noted prior to transfer.
  - (f) If an evaluatee is enrolled (or will be enrolled based on new assignment) in the Occupational Medical Surveillance and Evaluation Program (OMSEP), ensure appropriate periodic/basic examination is performed.
- g. Applicant.
- (1) Commissioning Programs. A physical examination is required for applicants for entry into the CG as follows:
    - (a) CG Academy: DODMERB physical examination within 24 months.
    - (b) Officer Candidate School: MEPS physical within 24 months of entry date, except.
      - [1] CG personnel on active duty may obtain the physical examination at a USMTF within 24 months of entry date.
      - [2] Members of other Armed Services may submit a physical examination from a USMTF provided the examination has been performed within the past twelve (12) months and is as complete as a MEPS physical examination.
    - (c) Direct commission: MEPS physical within 24 months of entry date or oath of office for Ready Reserve Direct Commission, except aviation

programs, where examination by a Uniformed Service Flight Surgeon or AMO is required within 12 months of entry date.

- (d) Applicants for service academies, ROTC scholarship programs, and the Uniformed Services University School of Health Sciences (USUHS) are authorized to utilize MTFs for their initial physical examination and additional testing if necessary. (Office of Assistant Secretary of Defense Health Affairs, OASD (HA) policy memo 9900003/Physical Examinations for ROTC Applicants (notal)).

[1] Applicants for entry into these program and prospective flight personnel should be treated as mission related priorities with scheduling precedence associated with priority group 1.

[2] Scheduling of physical examinations, additional tests and evaluations are to be conducted in a timely manner.

- (2) Aviation. An aviation physical examination is required for applicants for training in all categories of aviation specialties. This physical examination is valid for 24 months for aircrew applicants and 12 months for pilot applicants.

- (3) Diving. A dive applicant physical examination is required for all applicants for duty involving diving, and is valid for twelve months.

- h. Pre-Training Screening Examinations. A screening examination is required within 1 week of reporting to the CG Academy, Officer Candidate School, Direct Commission Officer orientation, or the Recruit Training Center. This screening examination shall be sufficiently thorough to ensure that the person is free from communicable and infectious diseases, and is physically qualified. The results of this examination shall be recorded on a Chronological Record of Medical Care, Form SF-600 and filed in the health record.

- i. Aviation/Landing Signal Officer.

- (1) Annual. An annual physical examination, consisting of the Report of Medical Examination, Form DD-2808, and Report of Medical History, Form DD-2807-1, and completion of the appropriate health risk assessment is required on all aviation personnel age 50 or older.

- (2) Biennial.

- (a) Biennial physical examination is required every 2 years after initial designation, until age 49, for the following:

[1] All aviation personnel (including air traffic controllers). The initial physical examination (which will count as the PHA) will consist of the Report of Medical Examination, Form DD-2808 and Report of

Medical History, Form DD-2807-1, and completion of the Navy Fleet and Marine Corps Health Risk Assessment (HRA).

Subsequent annual aviation physical examinations will alternate between the FDME (long form) and FDHS (short form) until age 50 years.

[2] All Landing Signal Officer (LSO).

- (b) The biennial exam will be performed either within 2 months prior to the members birth month or during the members birth month. The period of validity of the biennial physical will be aligned with the last day of the service member's birth month. (Example: someone born on 3 October would have August, September, and October in which to accomplish his/her physical. No matter when accomplished in that time frame, the period of validity of that exam is until 31 October two years later).
- (c) The requirement to perform a biennial exam will not be suspended in the event of training exercises or deployment. Aircrew with scheduled deployment during their 90 day window to accomplish their biennial exam may accomplish their biennial exam an additional 90 days prior and continue with the same valid end date. This may result in a member having a valid biennial for 30 months. Members unable to accomplish a biennial exam prior to being deployed will be granted an additional 60 days upon return in which to accomplish their physical.
- (d) Additionally, a comprehensive physical may be required during a post-mishap investigation, MEB, or as part of a work-up for a medical disqualification.
- (e) Aviation designated personnel are expected to maintain a biennial exam schedule regardless of current aviation duty status.
- j. Dive Officers. A physical examination is required every five (5) years for all personnel maintaining a current diving qualification (also note "Other" in Item #15.c. of Report of Medical Examination, Form DD-2808)
- k. PHS Officers.
  - (1) Triennial. A physical examination is required every three (3) years for all PHS officers detailed to the CG who are 50 years of age or older.
  - (2) Quinquennial. A physical examination is required every five (5) years for all personnel maintaining a current diving qualification (also note "Other" in Item #15.c. of Report of Medical Examination, Form DD-2808) and for all PHS officers under age 50 detailed to the CG (per PHS policy).

- l. OMSEP. Those individuals who are occupationally exposed to hazardous substances, physical energies, or employed in designated occupations must undergo physical examinations or screenings as required by Chapter 12 of this Manual.
- m. Miscellaneous Physical Examinations.
  - (1) Retention Examination. This examination is done at the direction of the Commanding Officer when there is substantial doubt as to a member's physical or mental fitness for duty. A District Commander may require any reservist attached to a command within that area to undergo a complete physical examination if reasonable doubt exists as to the reservist's physical or mental fitness for duty.
  - (2) Pre-confinement Physical Screening. In general, personnel who are presented for this screening, who do not require acute medical treatment or hospitalization, are fit for confinement. Cases where a member requires more than routine follow-up medical care, or has certain psychiatric conditions, that may make them unfit for confinement, should be discussed with the Chief Medical Officer (or his/her representative) at the confining facility. Personnel requiring detoxification for alcohol or drug dependency are not fit for confinement; however, members that have been detoxified or that may require rehabilitation alone are fit for confinement. This screening shall be recorded on a Chronological Record of Medical Care, Form SF-600 and together with a copy of the last complete and approved Report of Physical Examination Form, Form DD-2808 and Report of Medical History, Form DD-2807-1 shall be submitted to the Reviewing Authority.
  - (3) Post Confinement Physical Examination. Ensure a separation physical examination has been completed prior to the member departing the confining facility. The separation physical shall meet the standards of Section 3-F and must be approved by HSWL SC.
  - (4) Non-Fitness for Duty Determination Physical Examinations. The Senior Health Services Officer (SHSO) retains the authority and responsibility to determine capability and capacity to conduct non-fitness for duty physical examinations for all eligible beneficiaries.
  - (5) Medical Evaluation Boards (MEB). Medical Evaluation Boards are convened to evaluate the present state of health and fitness for duty of any active duty/selected reserve member.
- n. Dental Examinations. Annual Type II dental examinations are required for all active duty and SELRES members.



## 8. Waiver of Physical Standards.

- a. Definition of Waiver. A waiver is an authorization to retain the member when an individual does not meet the physical standards prescribed for the purpose of the examination.

- (1) Normally, a waiver will be granted when it is reasonably expected that the individual will remain fit for duty and the waiver is in the best interests of the CG. A service member will not be granted a waiver for a physical disability determined to be not fit for duty by a physical evaluation board approved by the Commandant. In these cases, the provisions for retention on active duty contained in the Physical Disability Evaluation System, COMDTINST M1850.2 (series) and the Military Separations, COMDTINST M1000.4 (series) apply.
- (2) If a member is under consideration by the physical disability evaluation system, no medical waiver request shall be submitted for physical defects or conditions described in the medical board. All waiver requests received for conditions described in the medical board will be returned to the member's unit without action.
- (3) A waiver of a physical standard is not required in a case where a Service Member's ability to perform on duty has been reviewed through the physical disability evaluation system and the approved finding of the Commandant is fit for duty.

- b. Authority for Waivers. Commander PSC-epm (enlisted), PSC-opm (officers), PSC-rpm (reserve), and CGRC (enlisted accessions) have the sole authority to grant waivers. The decision to authorize a waiver is based on many factors, including the recommendations of the Chief, Office of Health Services, Commandant (CG-112); the best interest of the Service; and the individual's training, experience, and duty performance. Waivers are not normally authorized but shall be reviewed by Commander (PSC) or CGRC for the following:

- (1) Original enlistment in the regular CG of personnel without prior military service (CGRC).
- (2) Appointment as a Cadet at the CG Academy (PSC).

Training in any aviation or diving category specialty (PSC).

- c. Types of Waivers. A waiver can be terminated if there is appropriate medical justification.

- (1) Temporary. A temporary waiver may be authorized when a physical defect or condition is not stabilized and may either progressively increase



or decrease in severity. These waivers are authorized for a specific period of time and require medical reevaluation prior to being extended.

- (2) Permanent. A permanent waiver may be authorized when a defect or condition is not normally subject to change or progressive deterioration, and it has been clearly demonstrated that the condition does not impair the individual's ability to perform general duty, or the requirements of a particular specialty, grade, or rate.

d. Procedures for Recommending Waivers.

- (1) Medical Officer. A Medical Officer who considers a defect disqualifying by the standards, but not a disability for the purpose for which the physical examination is required, shall:

- (a) Enter a detailed description of the defect in Item 77 of the Report of Medical Examination, Form DD-2808.
- (b) Indicate that either a temporary or permanent waiver is recommended.

- (2) Command/Unit Level. When the command receives a Report of Medical Examination, Form DD-2808 indicating that an individual is not physically qualified, the command shall inform the individual that he/she is not physically qualified. The individual shall inform the command via letter of his/her intentions to pursue a waiver. The Medical Officer is required to give a recommendation on whether the waiver is appropriate and if the individual may perform his/her duties with this physical defect. This recommendation shall be completed on a Medical Record, Form SF-507. A cover letter stating the command's opinion as to the appropriateness of a waiver, the individual's previous performance of duty, special skills, and any other pertinent information, shall accompany the Medical Officers report. The waiver request package shall be forwarded directly from the member's unit to Commander PSC-epm or opm, or Commandant (PSC-rpm) as appropriate.

- e. Command Action on Receipt of a Waiver Authorization. A command receiving authorization from the Commander PSC-epm/opm/rpm for the waiver of a physical standard shall carefully review the information provided to determine any duty limitation imposed and specific instructions for future medical evaluations. Unless otherwise indicated in the authorization, a waiver applies only to the specific category or purpose for which the physical examination is required. A copy of the waiver authorization shall be retained in both the service and health records for the period for which the waiver is authorized. Copies of future Report of Medical Examination, Form DD-2808 for the same purpose shall be endorsed to indicate a waiver is or was in effect.

9. Substitution of Physical Examinations.

- a. Rule for Substitution of Physical Examinations. In certain circumstances a physical examination performed for one purpose or category may be substituted to meet another requirement provided the following criteria are met:
  - (1) The examinee was physically qualified for the purpose of the previous examination and all the required tests and recommendations have been completed.
  - (2) The Report of Medical Examination, Form DD-2808 used for substitution bears an endorsement from the Reviewing Authority or Commandant (CG-112), as appropriate, indicating that the examinee was qualified for the purpose of the previous examination.
  - (3) There has been no significant change in the examinee's medical status since the previous examination.
  - (4) A review of the report of the previous examination indicates that the examinee meets the physical standards of the present requirement.
  - (5) The date of the previous examination is within the validity period of the present requirement.
  - (6) All additional tests and procedures to meet the requirements of the current physical examination have been completed.
- b. No substitutions are authorized for the following physical examinations:
  - (1) Enlistment.
  - (2) Pre-training.
  - (3) Applicants for or designated personnel in special programs (aviation, diving, Academy).
- c. Procedures for Reporting Substitution. Substitutions of a physical examination shall be reported by submitting a copy of the Report of Medical Examination, Form DD-2808 and Report of Medical History, Form DD-2807-1 being used to meet the present requirements with the appropriate endorsements. Retain a copy of the substitution endorsement in the health record.



- B. Report of Medical History, Form DD-2807-1 / Report of Medical Examination, Form DD-2808.
1. Report of Medical History, Form DD-2807-1.
    - a. Report of Medical History, Form DD-2807-1. The Report of Medical History, Form DD-2807-1 is the proper form for reporting a member's medical history. The Report of Medical History, Form DD-2807-1 can be obtained from the Commandant (CG-1121) Publications and Directives web site at <http://www.uscg.mil/hq/cg1/cg112/pubs.asp> or by <http://www.dtic.mil/whs/directives/infomgt/forms/eforms/dd2807-1.pdf> directly from the DOD forms web site.
    - b. Detailed instructions. On the preparation and distribution of this form are contained in Section 4-B of this Manual.
  2. Report of Medical History, Form DD-2808.
    - a. Report of Medical Examination, Form DD-2808. The Report of Medical Examination, Form DD-2808 is the proper form for reporting a complete physical examination. The Report of Medical Examination, Form DD-2808 can be obtained from the Commandant (CG-1121) Publications and Directives web site at <http://www.uscg.mil/hq/cg1/cg112/pubs.asp> or by <http://www.dtic.mil/whs/directives/infomgt/forms/eforms/dd2808.pdf> directly from the DOD forms web site.
    - b. Detailed instructions for the preparation and distribution of this form are contained in Section 4-B of this Manual.
  3. Findings and Recommendations of Report of Medical Examination, Form DD-2808.
    - a. Action by the Medical Examiner.
      - (1) Review of Findings and Evaluation of Defects. When the results of all tests have been received and evaluated, and all findings recorded, the examiner shall consult the appropriate standards of this chapter to determine if any of the defects noted are disqualifying for the purpose of the physical examination. When physical defects are found that are not listed in the standards as disqualifying, but that in the examiner's opinion would preclude the individual from performing military service or the duties of the program for which the physical examination was required, the examiner shall state that opinion on the report indicating reasons. If in the examiner's opinion, a defect listed as disqualifying is not disabling for military service, or a particular program, the examiner shall indicate the basis for this opinion and recommend a waiver in accordance with the provisions of Section A of this Chapter.
      - (2) Remediable Defects. When the physical examination of active duty personnel indicates defects that are remediable or that may become potentially disabling unless a specific medical program is followed, the

examiner shall clearly state any recommendations. If the examining facility has the capability of correcting the defect or providing extended outpatient follow-up or medical care, tentative arrangements for care shall be scheduled, subject to the approval of the examinee's command. If the examining facility does not have the capabilities of providing the necessary care, tentative arrangements for admission or appointment at another facility shall be scheduled, again subject to the approval of the individual's command.

- (3) Advising the Examinee. After completing the physical examination, the medical examiner will advise the examinee concerning the findings of the physical examination. At the same time, the examinee shall be informed that the examiner is not an approving authority for the purpose of the examination and that the findings must be approved by proper authorities.
- (4) Disposition of Reports. The original Report of Medical Examination, Form DD-2808 and the original Report of Medical History, Form DD-2807-1, together with any reports of consultations or special testing reports not entered on the Report of Medical Examination, Form DD-2808 or Report of Medical History, Form DD-2807-1, shall be forwarded to the activity that referred the individual for the physical examination.

c. Review and Action on Reports of Physical Examination by Command.

- (1) Command Responsibility.
  - (a) The command has a major responsibility in ensuring the proper performance of physical examinations on personnel assigned and that physical examinations are scheduled sufficiently far in advance to permit the review of the findings and correction of medical defects prior to the effective date of the action for which the examination is required. The command is also responsible to ensure that the individual complies with the examiner's recommendations and to initiate any administrative action required on a Report of Medical Examination.
  - (b) All Report of Medical Examination, Form DD-2808 shall be reviewed by Commanding Officers, or their designee, to determine that the prescribed forms were used and that all necessary entries were made.
  - (c) When the medical examiner recommends further tests or evaluation, or a program of medical treatment (such as hearing conservation, periodic blood pressure readings, etc.), the command will ensure that these tests or examinations are completed or that the individual is directed to and does comply with the recommended program. When a necessary test, evaluation, or program can be completed within a 60 day period, the unit may

hold the Report of Medical Examination, Form DD-2808 to permit the forwarding of results. In all cases the command shall endorse the Report of Medical Examination, Form DD-2808 to indicate what action has been taken and forward the report to the reviewing authority if the 60 day period cannot be met or has elapsed.

(d) Disposition of Reports.

- [1] If a physical examination is accomplished for a purpose for which the command has administrative action, the original Report of Medical Examination, Form DD-2808 and Report of Medical History, Form DD-2807-1 and a return self-addressed envelope shall be forwarded to the reviewing authority. No action will be taken to accomplish the purpose for which the physical examination was taken until the endorsed original of the report is returned by the reviewing authority indicating the examinee meets the physical standards for the purpose of the examination.
- [2] Approved MEPS physicals do not require further review. The original physical (Report of Medical Examination, Form DD-2808 and Report of Medical History, Form DD-2807-1) will be carried to the Training Center by the individual.
- [3] If the physical examination is for a purpose requiring the consent or approval of either Commandant or HSWL SC, the procedures previously described for command review and action will be accomplished, except rather than forwarding the report of the examination directly to the reviewing authority, it will be included with other supporting documents (letters, recommendations, etc.) and forwarded through the chain of command.
- [4] Units not using a CG health care facility shall send physical examinations to the appropriate CG clinic (as designated by HSWL SC or PSC (opm or epm) as appropriate.

d. Action by the Reviewing Authority.

- (1) The Commandant is the final reviewing authority for all physical examinations, except for applicants to the CG Academy.
- (2) Reviewing authorities are listed in Figure 3-B-2.
- (3) Flight physicals performed on aviators and aviation school students during training. Aviation physical exams that are completed and reviewed by the Navy Aerospace Medicine Institute (NAMI) or other armed services Flight Surgeons are considered valid. HSWL SC will not be the approving authority for these physicals. PSC will remain the waiver approval authority for these physicals, when a waiver is required prior to final approval. Upon completion of flight training and/or

assignment to a CG unit, the approved physical will be considered valid until the last day of the member's next birth month. The unit Flight Surgeon will clear the aviator for all flight related duties based on the approved flight physical.

- (4) Commander, Personnel Service Center (PSC-c) is the reviewing authority for aviator candidate, aircrew candidate, and diving candidate physical examinations. Commander, CGRC shall review disapproved MEPS physicals to ensure proper application of physical standards.
- (5) The Department of Defense Medical Examination Review Board (DODMERB) is the reviewing authority for physical examinations performed on Academy applicants. MEPS is the reviewing authority for physical examinations performed in their facilities.
- (6) Each Report of Medical Examination, Form DD-2808 shall be carefully reviewed to determine whether the findings reported indicate the examinee does or does not meet the appropriate physical standards. If further medical evaluation is required to determine that the examinee does meet the standards, or to resolve doubtful findings, the reviewing authority shall direct the Commanding Officer or recruiting station to obtain the evaluation and shall provide such assistance as may be required.
- (7) The reviewing authority shall endorse the original of the Report of Medical Examination, Form DD-2808 indicating whether the examinee does or does not meet the physical standards required. This endorsement, if at all possible, should be placed in Item 44 of the Report of Medical Examination, Form DD-2808 (if there is no room, place endorsement in Item 73). See Figure 3-B-1 for an example of the endorsement. The date of the endorsement should be no more than 60 days from the start of the physical. If more than 60 days have elapsed, indicate why on the endorsement or disapprove the physical.
- (8) The endorsed original of the physical examination shall be forwarded to the individual's unit for filing in the member's health record.
- (9) Enter all approved physicals into the Medical Readiness Reporting System (MRRS). The date entered is the date the member received their physical (dated entered on the Report of Medical Examination, Form DD-2808). Do not enter an unapproved physical into MRRS.

e. Disposition of Reports.

- (1) When the individual meets the appropriate physical standards, forward the physical examination as indicated in Figure 3-B-2.
- (2) When the individual does not meet the appropriate physical standards and a waiver has been recommended, endorse the physical examination and forward it in accordance with Section 3-A-8.



- (3) When the individual is not physically qualified for the purpose of the examination and a waiver is not recommended, the reviewing authority will arrange for the examinee to be evaluated by a medical board and provide administrative action as outlined in the Physical Disability Evaluation System, COMDTINST M1850.2 (series).

4. Correction of Defects Prior to Overseas Transfer or Sea Duty Deployment.

- a. Medical Defects. Before an individual departs for an overseas assignment for 60 consecutive days or greater, to permanent assignment aboard a Polar Icebreaker, or to a vessel deploying from its home port for 60 consecutive days or greater, all remediable medical defects, such as hernias, pilonidal cysts or sinuses requiring surgery, etc., must be corrected. Those defects that are not easily corrected will be referred to Commander PSC for consideration. These procedures also apply to personnel presently assigned to such vessels. In these cases all necessary corrective measures or waivers will be accomplished prior to the sailing date.
- b. Dental Defects. All essential dental treatment shall be completed prior to overseas transfer or sea duty deployment except those described in 4-C-3.c (3) (b). Essential dental treatment constitutes those procedures necessary to prevent disease and disabilities of the jaw, teeth, and related structures. This includes extractions, simple and compound restorations, and treatment for acute oral pathological conditions such as Vincent's stomatitis, acute gingivitis, and similar conditions that could endanger the health of the individual during a tour of duty. Missing teeth are to be replaced when occluding tooth surfaces are so depleted that the individual cannot properly masticate food. Elective dental procedures (those that may be deferred for up to twelve months without jeopardizing the patient's health, i.e., Class II patient need not be completed prior to overseas transfer providing both of the following conditions exist:
  - (1) Completion of such elective procedures prior to transfer would delay the planned transfer.
  - (2) Adequate Service dental facilities are available at the overseas base.
- c. Vision Defects. A refraction shall be performed on all personnel whose visual acuity is less than 20/20 in either eye (near or distant) or whose present eyewear prescription does not correct their vision to 20/20. All personnel requiring glasses for correction shall have a minimum of two pair prior to overseas transfer or sea duty deployment. All personnel requiring corrective lenses shall wear them for the performance of duty.

5. Objection to Assumption of Fitness for Duty at Separation.

- a. Member's responsibilities. Any member undergoing separation from the service that disagrees with the assumption of fitness for duty and claims to

have a physical disability as defined in section 2-A-38 of the Physical Disability Evaluation System, COMDTINST M1850.2 (series), shall submit written objections within 10 days of signing the Chronological Record of Service, Form CG-4057 to Commander PSC. Such objections based solely on items of medical history or physical findings will be resolved at the local level. The member is responsible for submitting copies of the following information along with the written objections:

- (1) Report of Medical Examination, Form DD-2808.
  - (2) Report of Medical History, Form DD-2807-1.
  - (3) Signed copy of the Chronological Record of Service, Form CG-4057.
  - (4) Appropriate consultations and reports.
  - (5) Other pertinent documentation.
  - (6) The rebuttal is a member's responsibility and command endorsement is not required.
- b. Rebuttal package. The package shall contain thorough documentation of the physical examination findings, particularly in those areas relating to the individual's objections. Consultations shall be obtained to thoroughly evaluate all problems or objections the examinee indicates. Consultations obtained at the examinee's own expense from a civilian source shall also be included with the report.
- c. Commander (PSC) responsibility. Commander (PSC) will evaluate each case and based upon the information submitted take one of the following actions:
- (1) Find separation appropriate, in which case the individual will be so notified and the normal separation process completed.
  - (2) Find separation inappropriate, in which case the entire record will be returned and appropriate action recommended.
  - (3) Request additional documentation before making a determination.
6. Separation Not Appropriate by Reason of Physical Disability. When a member has an impairment (in accordance with Section 3-F of this Manual) an Initial Medical Board shall be convened only if the conditions listed in paragraph 2-C-2.(b), Physical Disability Evaluation System, COMDTINST M1850.2 (series), are also met. Otherwise the member is suitable for separation.
7. Procedures for Physical Defects Found Prior to Separation.
- a. Policy. No person shall be separated from the Service with any disease in a communicable state until either rendered noninfectious, or until suitable provisions have been made for necessary treatment after separation.

- b. Remediable Non-Disqualifying Defects. Remediable physical defects that would not normally prevent the individual from performing the duties of grade or rate shall be corrected only if there is reasonable assurance of complete recovery and sufficient time remaining prior to separation.

## FIGURE 3-B-1

DATE: \_\_\_\_\_ REVIEWERS UNIT \_\_\_\_\_

Does /does not meet the physical standards for (title or category or purpose of examination), as prescribed in (appropriate section of Medical Manual, COMDTINST M6000.1 (series)).

Disqualifying Defects:

Signature and Title of Reviewer

FIGURE 3-B-2

<b>Physical Exam Purpose</b>	<b>Note:</b>	<b>Approving Authority</b>	<b>Reviewing Authority:</b>
Aviator Candidate	(1,2)	PSC-PSD-med	PSC-c
Aircrew Candidate	(1,2)	PSC-PSD-med	PSC-c
Diving Candidate	(1,6)	NDSTC	HSWL SC
Physician Assistant Candidate	(1,4)	PSC-opm	PSC-c
Flight Surgeon (FS)		PSC-PSD-med	PSC-PSD-med
FS Candidate	(1)	PSC-PSD-med	PSC-PSD-med
Aviator	(1)	PSC-PSD-med	PSC-PSD-med
Aircrew	(1)	PSC-PSD-med	PSC-PSD-med
Diving	(1)(5)	Designated DMO	Designated DMO
LSO	(1)	HSWL SC or HSA	HSWL SC or HSA
Overseas/Sea Duty	(1)(7)	HSWL SC or HSA	HSWL SC or HSA
PHS Officer (non-FS)	(1)	HSWL SC or HSA	HSWL SC or HSA
Retention	(1)	HSWL SC or HSA	HSWL SC or HSA
Retirement	(1,3)	HSWL SC or HSA	HSWL SC or HSA
Involuntary Separation	(1,3)	HSWL SC or HSA	HSWL SC or HSA
Precom /Appts	(1)	HSWL SC or HSA	HSWL SC or HSA
Direct Commission	(1,4)	CGRC	CGRC
OCS	(1,4)	CGRC	CGRC
Enlistment	(2)	CGRC	CGRC

## NOTES:

- (1) The reviewing authority shall review, endorse and return the original to the member's unit for filing in the member's or applicant's health record. Aviation and Diving physical examinations will be routed electronically via AERO.
- (2) Forward the unendorsed physical to the appropriate office (as listed above) with the application/training request package. That office will forward the physical to CG PSC for review. Aviation and Diving physical examinations will be routed electronically via AERO.
- (3) Ensure that a completed Chronological Record of Care, Form CG-4057 accompanies the completed Report of Medical Examination, Form DD-2808 and Report of Medical History, Form DD-2807-1.
- (4) Reviewing authority for current USCG or USCGR members only. For all others, Note (2) above applies. Forward a copy of the first/front page of the Report of Medical Examination, Form DD-2808 with endorsement to the appropriate office with the application package.
- (5) Diving Medical Officer (DMO) will be designated by Commandant (CG-1121). The currently designated DMO is listed on the Operational Medicine website.

FIGURE 3-B-2 (cont)

- (6) Diving candidate physicals shall be forwarded by HSWL SC to Coast Guard Liaison Office (CGLO) at COMMANDING OFFICER, NAVAL DIVING SALVAGE TRAINING CENTER, 350 CRAG RD, PANAMA CITY FL 32407-7016. CGLO will notify member of status of physical exam. Physical exam will be retained at NDSTC until member commences training at which time the physical exam will be entered into the health record.
- (7) If the Health Services Administrator is a Warrant Officer, he or she can review and approve of the Overseas/Sea Duty screening. If not, HSWL SC is designated reviewing/approval authority.

C. Medical Examination Techniques and Lab Testing Standards.

1. Scope. This section is a medical examination technique guide applicable for all physical examinations and periodic health assessments (PHA). Detailed instructions for the PHA are contained in the Coast Guard Periodic Health Assessment, COMDTINST M6150.3 (series).
2. Speech Impediment. Administer the "Reading Aloud Test" (RAT) as listed.
  - a. Procedure. Have the examinee stand erect, face you across the room and read aloud, as if confronting a class of students.
  - b. Pauses. If the individual pauses, even momentarily, on any phrase or word, immediately and sharply ask, "What's that?", and require the examinee to start over again with the first sentence of the test.
  - c. Second trial. The person who truly stammers usually will halt again at the same word phonetic combination often revealing serious stammering. Examinees who fail to read the test without stammering after three attempts will be disqualified.
  - d. Reading aloud test. "You wished to know all about my grandfather. Well, he is nearly 93 years old; he dresses himself in an ancient black frock coat usually minus several buttons; yet he still thinks as swiftly as ever. A long, flowing beard clings to his chin, giving those who observe him a pronounced feeling of the utmost respect. When he speaks, his voice is just a bit cracked and quivers a trifle. Twice each day he plays skillfully and with zest upon our small organ. Except in the winter when the ooze or snow or ice is present, he slowly takes a short walk in the open air each day. We have often urged him to walk more and smoke less, but he always answers, 'Banana Oil.' Grandfather likes to be modern in his language."
3. Head, Face, Neck, and Scalp (Item 17 of the Report of Medical Examination, Form DD-2808).
  - a. Head and Face. Carefully inspect and palpate the head and face for evidence of injury, deformity, or tumor growth. Record all swollen glands, deformities, or imperfections noted. Inquire into the cause of all scars and deformities. If a defect is detected such as moderate or severe acne, cysts, or scarring, make a statement as to whether this defect will interfere with wearing military clothing and equipment.
  - b. Neck. Carefully inspect and palpate for glandular enlargement, deformity, crepitus, limitations of motion, and asymmetry; palpate the parotid and submaxillary regions, the larynx for mobility and position, the thyroid for size and nodules, and the supraclavicular areas for fullness and masses. If enlarged lymph nodes are detected describe them in detail with a clinical opinion of their etiology.

- c. Scalp. Examine for deformities such as depressions and exostosis dermatologic conditions, or infestations with parasites (i.e. head lice).
4. Nose, Sinuses, Mouth, and Throat (Item 19, 20 of the Report of Medical Examination, Form DD-2808).
  - a. Nasal or sinus complaints. If there are no nasal or sinus complaints, simple anterior rhinoscopy will suffice, provided that in this examination, the nasal mucous membrane, the septum, and the turbinates appear normal. If the examinee has complaints, a more detailed examination is required. Most commonly, these complaints are external nasal deformity, nasal obstruction, partial or complete on one or both sides (which require comment on free passage of air past the obstruction); nasal discharge; postnasal discharge; sneezing; nasal bleeding; facial pain; and headaches.
  - b. Abnormalities in the mucous membrane. Abnormalities in the mucous membrane in the region of the sinus ostia, the presence of pus in specific areas, and the cytologic study of the secretions may provide valuable information regarding the type and location of the sinus infection. Evaluate tenderness over the sinuses by transillumination or x-ray. Examination for sinus tenderness should include pressure applied over the anterior walls of the frontal sinuses and the floors of these cavities and also pressure over the cheeks. Determine if there is any tenderness to percussion beyond the boundaries (as determined by x-ray) of the frontal sinuses. Note any sensory changes in the distribution of the supra-orbital or infra-orbital nerves that may indicate the presence of neoplasm. Note any external swelling of the forehead, orbit, cheek, and alveolar ridge.
  - c. Mouth and tongue. Many systemic diseases manifest themselves as lesions of the mouth and tongue; namely leukemia, syphilis, agranulocytosis, pemphigus, erythema multiform, and dermatitis medicamentosa. Note any abnormalities or lesions on lips or buccal mucous membrane, gums, tongue, palate, floor of mouth, and ostia of the salivary ducts. Note the condition of the teeth. Pay particular attention to any abnormal position, size, or the presence of tremors or paralysis of the tongue and the movement of the soft palate on phonation.
  - d. Throat. Record any abnormal findings of the throat. If tonsils are enucleated, note possible presence and position of residual or recurrent lymphoid tissue and the degree of scarring. If tonsils are present, note size, presence of pus in crypts, and any associated cervical lymphadenopathy. Note presence of exudate, ulceration, or evidence of neoplasm on the posterior pharyngeal crypts. Describe any hypertrophied lymphoid tissue on the posterior pharyngeal wall or in the lateral angle of the pharynx and note if there is evidence of swelling that displaces the tonsils, indicating possible neoplasm or abscess. Perform direct or indirect laryngoscopy if the individual complains of hoarseness.



5. Ears (General) and Drums (Item 21, 22 of the Report of Medical Examination, Form DD-2808). Inspect the auricle, the external canal, and the tympanic membrane using a speculum and good light. Abnormalities (congenital or acquired) in size, shape, or form of the auricles, canals, or tympanic membranes must be noted, evaluated, and recorded.
  - a. Auricle. Note deformities, lacerations, ulcerations, and skin disease.
  - b. External canal. Note any abnormality of the size or shape of the canal and inspect the skin to detect evidence of disease. If there is material in the canal, note whether it is normal cerumen, foreign body, or exudate. Determine the source of any exudate in the canal. If this exudate has its origins in the middle ear, record whether it is serous, purulent, sanguinous, or mucoid; whether it is foul smelling; and, whether it is profuse or scanty.
  - c. Tympanic membrane. Remove all exudate and debris from the canal and tympanic membrane before examination. Unless the canal is of abnormal shape, visualize the entire tympanic membrane and note and record the following points.
    - (1) List any abnormality of the landmarks indicating scarring, retraction, bulging, or inflammation.
    - (2) Note whether the tympanum is air containing.
    - (3) List any perforations, giving size and position, indicating whether they are marginal or central, which quadrant is involved, and whether it is the flaccid or the tense portion of the membrane that is included.
    - (4) Attempt, if the tympanic membrane is perforated, to determine the state of the middle ear contents, particularly concerning hyperplastic tympanic mucosa, granulation tissue, cholesteatoma, and bone necrosis. This clinical objective examination should permit evaluating the infectious process in the middle ear and making a reasonably accurate statement regarding the chronicity of the infection; the extent and type of involvement of the mastoid; the prognosis regarding hearing; and, the type of treatment (medical or surgical) that is required.
    - (5) Note, for all aviation and dive physical examinations, whether the examinee can properly auto- insufflate the tympanic membrane.
6. Eyes (General), Ophthalmoscopic, and Pupils (Item 23, 24, 25 of the Report of Medical Examination, Form DD-2808). External and ophthalmoscopic examinations of the eyes are required on all examinations. Contact lenses shall not be worn during any part of the eye examination, including visual acuity testing. It is essential that such lenses not be worn for 72 hours preceding examination. The strength of the contact lens that an examinee may possess shall not be accepted as the refraction nor will it be entered as such in Item 60,

Report of Medical Examination, Form DD-2808. The general examination shall include the following specific points and checks:

- a. General.
  - (1) Bony abnormality or facial asymmetry.
  - (2) Position of the eyes.
  - (3) Exophthalmus.
  - (4) Manifest deviation of the visual axis.
  - (5) Epiphora or discharge.
  - (6) Position of puncta or discharge when pressure exerted over lacrimal sac.
- b. Lids.
  - (1) Ptosis.
  - (2) Position of lashes, eversion or inversion.
  - (3) Inflammation of margins.
  - (4) Cysts or tumors.
- c. Conjunctiva. Examine the palpebral and bulbar conjunctiva by:
  - (1) Eversion of upper lid.
  - (2) Depression and eversion of lower lid.
  - (3) Manually separating both lids.
- d. Pupils.
  - (1) Size.
  - (2) Shape.
  - (3) Equality.
  - (4) Direct, consensual, and accommodative reactions.
- e. Directly and obliquely examine.
  - (1) Cornea. For clarity, discrete opacities, superficial or deep scarring, pannus, vascularization, pterygium, and the integrity of the epithelium.
  - (2) Anterior Chamber. For depth, alteration of normal character of the aqueous humor, and retained foreign bodies.

(3) Iris. For abnormalities and pathologic changes.

(4) Crystalline Lens. For clouding or opacities.

f. Ophthalmoscopic.

(1) Media. Examine with a plano ophthalmoscopic lens at a distance of approximately 18 to 21 inches from the eye. Localize and describe any opacity appearing in the red reflex or direct examination or on eye movement.

(2) Fundus. Examine with the strongest plus or weakest minus lens necessary to bring optic nerve into sharp focus. Pay particular attention to the color, surface, and margin of the optic nerve, also record any abnormality of the pigmentation or vasculature of the retina.

(3) Macula. Examine for any change.

7. Ocular Motility (Item 26 of the Report of Medical Examination, Form DD-2808).

- a. Ascertain the motility of the ocular globe by testing for binocular eye movement (ductions and versions) in the cardinal positions of gaze. If any abnormalities are suspected, verify with the cover/uncover test.
- b. Observe if the eyes move together and whether there is loss of motion in any direction (paralysis or paresis), or absence of muscle balance, whether latent (heterophoria) or manifest (strabismus / heterotropia). Have the examinee look at a test object and alternately cover and uncover one eye leaving the other uncovered and observe the movement, if any, in each eye. In heterotropia movement occurs only in the eye that is covered and uncovered; on being covered, it deviates and on being uncovered, it swings back into place to take up fixation with the other eye that has remained uncovered.

8. Heart and Vascular System (Item 27 of the Report of Medical Examination, Form DD-2808).

- a. General. In direct light, have the examinee stand at ease, with arms relaxed and hanging by sides. Do not permit the examinee to move from side to side or twist to assist in the examination, as these maneuvers may distort landmarks: and increase muscular resistance of the chest wall. Examine the heart by the following methods: inspection, palpation, auscultation, and when considered necessary, by mensuration.
- b. Inspection. Begin from above and go downward, with special reference to the following:
  - (1) Any malformation that might change the normal relations of the heart.

- (2) Pulsations in the suprasternal notch and in the second interspaces to the right and left of the sternum.
  - (3) Character of the precordial impulse.
  - (4) Epigastric pulsations.
- c. Palpation. First palpate to detect thrills over the carotids, thyroid glands, suprasternal notch, apex of the heart, and at the base. Use palms of hands in palpating and use light pressure, as hard pressure may obliterate a thrill. To locate the maximum cardiac impulse, have the examinee stoop and throw the shoulders slightly forward, thus bringing the heart into the closest possible relation with the chest wall. Place the palm of one hand over the heart and fingers of the other over the radial artery to see if all ventricular contractions are transmitted. Palpate both radial arteries at the same time for equality in rate and volume. Run the finger along the artery to note any changes in its walls. Palpate to determine the degree of tension or compression of the pulse. In an estimate of pulse rate, the excitement of undergoing a physical examination must be considered.
- d. Auscultation. In auscultating the heart, bear in mind the four points where the normal heart sounds are heard with maximum intensity:
- (1) Aortic area, second interspace to right of sternum. Here the second sound is distinct.
  - (2) Tricuspid area, junction of the fifth left rib with the sternum. Here the first sound is distinct.
  - (3) Pulmonic area, second interspace to left of sternum. Here the second sound is most distinct.
  - (4) Mitral area, fifth interspace in the midclavicular line. Here the first sound is most clearly heard.
- e. Blood Pressure.
- (1) Only the sitting blood pressure is required.
  - (2) Additional positions are required only if the sitting blood pressure exceeds 139 mmHG systolic or 89 mmHG diastolic.
  - (3) Take the sitting blood pressure with the examinee comfortably relaxed in a sitting position with legs uncrossed and the arm placed on a rest at the horizontal level of the heart. The condition of the arteries, the tenseness of the pulse, and the degree of accentuation of the aortic second sound must be taken into consideration, as well as the relation between the systolic and diastolic pressure.
  - (4) Personnel recording blood pressure must be familiar with situations that result in spurious elevation. A Medical Officer shall repeat the

determination in doubtful or abnormal cases and ensure that the proper recording technique was used.

- (5) Artificially high blood pressure may be observed as follows.
  - (a) If the compressive cuff is too loosely applied.
  - (b) If the compressive cuff is too small for the arm size. Cuff width should be approximately one-half arm circumference. In a very large or very heavily muscled individual, this may require an "oversize" cuff.
  - (c) If the blood pressure is repetitively taken before complete cuff deflation occurs. Trapping of venous blood in the extremity results in a progressive increase in recorded blood pressure.
- (6) At least five minutes of seated rest should precede the blood pressure recording. Due regard must be given to physiologic effects such as excitement, recent exercise, smoking or caffeine within the preceding thirty minutes, and illness.
- (7) No examinee shall be rejected based on the results of a single recording. If 2 out of the 3 positions exceed 139 mm HG systolic or 89 mm HG diastolic, the disqualifying blood pressures will be rechecked for 3 consecutive days in the morning and afternoon of each day and averaged. The first determination shall be recorded in Item 58 and the repeat determinations in Item 73 of the Report of Medical Examination, Form DD-2808. Patients being treated for HTN who have blood pressures less than 140 systolic and 90 diastolic do not require three-day blood pressure checks.
- (8) While emphasizing that a diagnosis of elevated blood pressure not be prematurely made, it seems evident that a single "near normal" level does not negate the significance of many elevated recordings.

f. Blood Pressure Determination.

- (1) Use procedures recommended by the American Heart Association.
- (2) Take the systolic reading as either the palpatory or auscultatory reading depending on which is higher. In most normal subjects, the auscultatory reading is slightly higher.
- (3) Record diastolic pressure as the level at which the Korotkoff sounds disappear by auscultation. In a few normal subjects, particularly in thin individuals and usually because of excessive stethoscope pressure, cardiac tones may be heard to extremely low levels. In these instances, if the technique is correct and there is no underlying valvular defect, a diastolic reading will be taken at the change in tone.
- (4) Note variations of blood pressures with the position change if there is a history of syncope or symptoms to suggest postural hypertension.

- (5) Obtain blood pressure in the legs when simultaneous palpation of the pulses in upper and lower extremities reveals a discrepancy in pulse volume.
- g. Pulse Rate.
- (1) Determine the pulse rate immediately after the blood pressure. Only the sitting position is required.
  - (2) In the presence of a relevant history, arrhythmia, or a pulse of less than 50 or over 100, an electrocardiogram will be obtained.
- h. Interpretation of Abnormal Signs and Symptoms. The excitement of the examination may produce violent and rapid heart action often associated with a transient systolic murmur. Such conditions may erroneously be attributed to the effects of exertion; they usually disappear promptly in the recumbent posture. Try to recognize the excitable individuals and take measures to eliminate psychic influences from the test.
- i. Hypertrophy-Dilatation. An apex beat located at or beyond the left nipple line, or below the sixth rib, suggests an enlargement sufficient to disqualify for military service. Its cause, either valvular disease or hypertension in the majority of cases, should be sought. A horizontal position of the heart must be distinguished from left ventricular enlargement. EKG, ultrasound studies, fluoroscopy, and chest x-ray may be indicated for diagnosis.
- j. Physiological Murmurs. Cardiac murmurs are the most certain physical signs by which valvular disease may be recognized and its location determined. The discovery of any murmur demands diligent search for other evidence of heart disease. Murmurs may occur, however, in the absence of valvular lesions or other cardiac disease. Such physiological murmurs are not causes for rejection.
- (1) Characteristics. The following characteristics of physiological murmurs will help differentiate them from organic murmurs:
    - (a) They are always systolic in time.
    - (b) They are usually heard over a small area, the most common place being over the pulmonic valve and mitral valve.
    - (c) They change with position of the body, disappearing in certain positions. They are loudest usually in the recumbent position and are sometimes heard only in that position.
    - (d) They are transient in character, frequently disappearing after exercise.
    - (e) They are usually short, rarely occupying all of the systole, and are soft and of blowing quality.

- (f) There is no evidence of heart disease or cardiac enlargement.
- (2) Most Common Types. The most common types of physiological murmurs are:
  - (a) Those heard over the second and third left interspaces during expiration, disappearing during forced inspiration. These are particularly common in individuals with flexible chests, who can produce extreme forced expiration. Under such circumstances, murmurs may be associated with a vibratory thrust.
  - (b) Cardio-respiratory murmurs caused by movements of the heart against air in a part of the lung overlapping the heart. They usually vary in different phases of respiration and at times disappear completely when the breath is held.
  - (c) Prolongations of the apical first sound that are often mistaken for murmurs.
- (3) Diagnosis. An EKG, chest x-ray, and echocardiogram are usually indicated to firmly establish the true cause of a murmur and should be done if there is any question of abnormality.
- k. Electrocardiograms. Use standard positions for precordial leads when completing electrocardiograms.
- 9. Lungs and Chest (Item 28 of the Report of Medical Examination, Form DD-2808).
  - a. History and x-ray studies. A thorough examination includes a complete history (Report of Medical History, Form DD-2807-1) careful physical examination, and necessary x-ray and laboratory studies.
  - b. Exam. Several disqualifying diseases such as tuberculosis and sarcoidosis may not be detectable by physical examination and the absence of abnormal physical signs does not rule out disqualifying pulmonary disease. Such diseases, as well as others (neoplasms and fungus infections), may be detected only by chest x-ray.
    - (1) Conduct the physical examination in a thorough, systematic fashion. Take particular care to detect pectus abnormalities, kyphosis, scoliosis, wheezing, persistent rhonchi, basilar rales, digital clubbing, and cyanosis. Any of these findings require additional inquiry into the patient's history if subtle functional abnormalities or mild asthma, bronchitis, or bronchiectasis are to be suspected and evaluated. The physical examination shall include the following:
      - (a) Inspection. The examinee should be seated with the direct light falling upon the chest. Careful comparison of the findings elicited



over symmetrical areas on the two sides of the chest gives the most accurate information regarding condition of the underlying structures. Observe for asymmetry of the thoracic cage, abnormal pulsation, atrophy of the shoulder girdle or pectoral muscles, limited or lagging expansion on forced inspiration. The large, rounded relatively immobile "barrel" chest suggests pulmonary emphysema.

(b) Palpation.

[1] Observe for tumors of the breast or thoracic wall, enlarged cervical, supraclavicular, or axillary lymph nodes, suprasternal notch, and thrills associated with respiration or the cardiac cycle.

[2] A breast examination should also be performed based upon the Clinical Preventive Services guidance as contained in the Coast Guard Periodic Health Assessment, COMDTINST 6150.3 (series). Monthly self-examination is recommended for all adult female patients.

(c) Auscultation. Instruct the examinee to breathe freely but deeply through the mouth. Listen to an entire respiratory cycle before moving the stethoscope bell to another area. Note wheezing, rales, or friction rubs. Compare the pitch and intensity of breath sounds heard over symmetrical areas of the two lungs. Instruct the examinee to exhale during this process. Note any rales, paying particular attention to moist rales that "break" with the cough or fine rales heard at the beginning of inspiration immediately after cough.

(2) Do not hesitate to expand the history if abnormalities are detected during examination or in repeating the examination if chest film abnormalities are detected.

c. Asthma bronchiectasis, and tuberculosis. There are three conditions that are most often inadequately evaluated and result in unnecessary and avoidable expense and time loss. These three are asthma (to include "asthmatic bronchitis"), bronchiectasis, and tuberculosis.

(1) Asthma. In evaluating asthma, a careful history is of prime importance since this condition is characteristically intermittent and may be absent at the time of examination. Careful attention to a history of episodic wheezing with or without accompanying respiratory infection is essential. Ask about the use of prescription or over-the-counter bronchodilators.

(2) Bronchiectasis. Individuals who report a history of frequent respiratory infections accompanied by purulent sputum or multiple episodes of pneumonia should be suspected of bronchiectasis. This diagnosis can be further supported by a finding of post-tussive rales at one or both bases posteriorly or by a finding of lacy densities at the lung base on the chest film. If bronchiectasis is considered on the basis of history, medical findings or chest film abnormalities seek confirmatory opinion from the examinee's personal physician or refer the examinee to a pulmonologist for evaluation and recommendations.

(3) Tuberculosis (TB).

- (a) Active TB is often asymptomatic and not accompanied by abnormal physical findings unless the disease is advanced. If only such manifestations as hemoptysis or draining sinuses are looked for, most cases of TB will be missed.
- (b) The QuantiFERON® - TB Gold test (QFT-G) or the Tuberculin Skin Test (TST) can aid in diagnosing Mycobacterium tuberculosis infection, including latent tuberculosis infection (LTBI) and tuberculosis (TB) disease.
- (c) If TB testing is positive, evaluate the chest film for any infiltrate, cavity, or nodular lesion involving the apical or posterior segments of an upper lobe or superior segment of a lower lobe. Many tuberculosis lesions may be partially hidden or obscured by the clavicles. When any suspicion of an apical abnormality exists, an apical lordotic view must be obtained for clarification.
- (d) It is neither practical nor possible, in most instances, to determine whether or not a TB lesion is inactive on the basis of a single radiologic examination. Therefore, refer any examinee suspected of TB to a pulmonologist or to an appropriate public health clinic for evaluation.
- (e) An initial TST is mandatory and shall be made a part of the physical examination for all personnel entering on active duty for a period of 30 days or more.
- (f) See [www.cdc.gov/tb/](http://www.cdc.gov/tb/) for additional information on Tuberculosis Management.

10. Anus and Rectum (Item 30 of the Report of Medical Examination, Form DD-2808). All examinations shall include a visual inspection of the anus. Perform a digital rectal examination and test for fecal occult blood in accordance with the Clinical Preventive Service guidelines as contained in the CG Periodic Health Assessment, COMDTINST 6150.3 (series). When anorectal disease is suspected a consultation with a gastroenterologist may be indicated.

11. Abdomen and Viscera (Item 31 of the Report of Medical Examination, Form DD-2808).
  - a. Examination. Examine the abdomen with the examinee supine, as well as standing to detect hernias.
  - b. Methods. Use appropriate clinical laboratory, radiologic, and endoscopic examinations to confirm a diagnosis.
  - c. Inspection. Observe for asymmetries, skin discoloration, visible mass, abdominal wall defects, and surgical scars.
  - d. Auscultation. Auscult all four abdominal quadrants using the stethoscope bell. Note quality and type of bowel sounds present or absence of sounds. Firm pressure with deep impression of the bell will also evaluate abdominal tenderness.
  - e. Palpation. Press lightly, then firmly in all four quadrants feeling for masses or organomegaly, also noting tenderness (if present, assess for guarding or rebound).
12. Genitourinary System (Item 32 of the Report of Medical Examination, Form DD-2808).
  - a. General. All physical examinations shall search for evidence of Sexually Transmitted Infections (STI) or malformation.
  - b. Instructions for examination according to sex.
    - (1) Females. The examination shall include:
      - (a) Inspection of the external genitalia.
      - (b) Either a vaginal or rectal bimanual palpation of the pelvic organs.
      - (c) Papanicolaou (Pap) testing and visualization of the cervix and vaginal canal by speculum in accordance with 20.f. of this Section.
    - (2) Males. The glans penis and corona will be exposed. The testes and scrotal contents will be palpated and the inguinal lymph nodes will be examined for abnormalities. Palpate the inguinal canals while having the patient perform a valsalva maneuver to detect hernias.
13. Extremities (Item 33, 34, 35 of the Report of Medical Examination, Form DD-2808). Carefully examine the extremities for deformities, old fractures and dislocations, amputations, partially flexed or ankylosed joints, impaired functions of any degree, varicose veins, and edema. In general the examination shall include:
  - a. Elbow. With the examinee holding the upper arms against the body with the forearms extended and fully supinated, observe for the presence of normal carrying angle. Have the examinee flex the elbows to a right angle and

keeping the elbows against the body, note ability to fully supinate and pronate the forearms. Test medial and lateral stability by placing varus and valgus strain on the joint with the elbow extended. Test the power of the flexor, extensor, supinator, and pronator muscles by having the examinee contract these muscles against manual resistance. If indicated, x-rays should include antero-posterior and lateral views.

b. Foot.

- (1) Examine the feet for conditions such as flatfoot, corns, ingrown nails, bunions, deformed or missing toes, hyperhidrosis, color changes, and clubfoot.
- (2) When any degree of flatfoot is found, test the strength of the feet by requiring the examinee to hop on the toes of each foot for a sufficient time and by requiring the examinee to alight on the toes after jumping up several times. To distinguish between disqualifying and nondisqualifying degrees of flatfoot, consider the extent, impairment of function, appearance in uniform, and presence or absence of symptoms. Remember, it is usually not the flatfoot condition itself that causes symptoms but an earlier state in which the arches are collapsing and the various structures are undergoing readjustment of their relationships. Report angles of excursion or limitation; comparative measurements; use of orthotics or other supports; and x-ray results if indicated.

c. Hip.

- (1) With the examinee standing, observe the symmetry of the buttocks, the intergluteal clefts, and infragluteal fold. Palpate the iliac crest and greater trochanters for symmetry.
- (2) If abnormalities are suspected, have the examinee stand first on one foot and then the other, flexing the nonweight bearing hip and knee and observing for ability to balance as well as for instability of the joint, as indicated by dropping downward of the buttock and pelvis of the flexed (non-weight bearing) hip. A positive Trendelenburg sign necessitates x-ray evaluation.
- (3) While supine have the examinee flex the hip, abduct and adduct the hip and rotate the leg inward. Observe for hesitancy in performing these motions, incomplete range of motion, or facial evidence of pain on motion. Test muscle strength in each position.
- (4) With examinee prone, test for ability to extend each leg with knee extended and test for power in each hip in extension.
- (5) If abnormalities are detected requiring x-rays, obtain an antero-posterior and a lateral view of each hip for comparison.

d. Knee.

- (1) With trousers (skirt/dress), shoes, and socks removed, observe general muscular development of legs, particularly the thigh musculature.
- (2) Have examinee squat, sitting on heels, and observe for hesitancy, weakness, and presence or absence of pain or crepitus.
- (3) With examinee sitting, test for ability to fully extend the knee and test power in extension by applying pressure to the lower leg with knee extended. Compare equality of power in each leg. With knee flexed, test for hamstring power by attempting to pull leg into extension; compare equality of strength in each leg. Palpate entire knee for tenderness. With examinee still sitting on the table edge, sit and grasp the heel between the knees; then test for cruciate ligament stability by first pulling the tibia anteriorly on the femur and by then pushing the tibia posteriorly on the femur ("Drawer Sign").
- (4) With the examinee supine, mark on each leg a distance of 1 inch above the patella and 6 inches above the patella, making sure this is done with muscles relaxed. Measure circumferences at these levels and note presence or absence of atrophy. Test the medial and lateral collateral ligaments by placing varus and valgus strain on the extended knee. Manipulate the knee through a complete range of flexion and extension, noting any difference between the sides and any abnormal restriction.
- (5) If there is a history of knee injury assess muscular strength, ligamentous stability, and range of motion. Also look for evidence of inflammatory or degenerative processes.
- (6) In the presence of any history of "locking," recurrent effusion, or instability, or when atrophy measured is more than 3/8 inch or when limitation of motion or ligamentous instability is detected, obtain x-rays including an antero-posterior, lateral, and intercondylar view.
- (7) An orthopedic evaluation is required on all recruit physicals if there is evidence of any abnormality.

e. Shoulder.

- (1) With the examinee stripped to the waist, inspect both anteriorly and posteriorly for asymmetry, abnormal configuration, or muscle atrophy.
- (2) From the back, with the examinee standing, observe the scapulohumeral rhythm as the arms are elevated from the sides directly overhead, carrying the arms up laterally. Any arrhythmia may indicate shoulder joint abnormality and is cause for particularly careful examination. Palpate the shoulders for tenderness and test range of motion in flexion, extension, abduction, and rotation. Compare each shoulder in this respect.

- (3) Test muscle power of abductors, flexors, and extensors of the shoulder, as well as power in internal and external rotation. Have the examinee attempt to lift a heavy weight with arms at the side to establish integrity of the acromioclavicular joint.

f. Wrist and Hand.

- (1) Palpate the wrist for tenderness in the anatomical snuff box often present in undiscovered fractures of the carpal navicular. Observe and compare muscle strength and range of motion, flexion, extension, radial, and ulnar deviation.
- (2) Inspect the palms and extended fingers for excessive perspiration, abnormal color or appearance, and tremor, indicating possible underlying organic disease.
- (3) Have the examinee flex and extend the fingers making sure interphalangeal joints flex to allow the finger tips to touch the flexion creases of the palm.
- (4) With the hands pronated, observe the contour of the dorsum of the hands for atrophy of the soft tissues between the metacarpals seen in disease or malfunction of peripheral nerves.
- (5) With the fingers spread, test for strength, and interosseous muscle function by forcing the spread fingers against the resistance of the examinee.
- (6) If indicated, obtain antero-posterior and lateral x-rays of the wrist, as well as antero-posterior and oblique views of the hand.

14. Spine and Other Musculoskeletal (Item 36 of the Report of Medical Examination, Form DD-2808). Carefully examine for evidence of intervertebral disc syndrome, myositis, and traumatic lesions of the low back (lumbosacral and sacroiliac strains). If there is any indication of congenital deformity, arthritis, spondylolisthesis, or significant degree of curvature, obtain orthopedic consultation and x-rays.

- a. Examination. With the examinee stripped and standing, note the general configuration of the back, the symmetry of the shoulders, iliac crests and hips, and any abnormal curvature. Palpate the spinous processes and the erector spinae muscle masses for tenderness. Determine absence of pelvic tilt by palpating the iliac crests. Have examinee flex and extend spine and bend to each side, noting ease with which this is done and the presence or absence of pain on motion. Test rotary motion by gripping the pelvis on both sides and having the examinee twist to each side as far as possible fully extend the knee, note complaints of pain (this corresponds to a 90 degree straight leg raising test in supine position).
- b. Reflexes. With the examinee sitting on the examining table, test patellar and ankle reflexes.

- c. Strength. With the examinee supine, test dorsiflexor muscle power of the foot and toes, with particular attention to power of the extensor hallucis longus. Weakness may indicate nerve root pressure on S1. Flex hip fully on abdomen and knee flexed and determine presence or absence of pain on extremes of rotation of each hip with hip flexed to 90 degrees. Frequently, in lumbosacral sprains of chronic nature, pain is experienced on these motions. Place the heel on the knee of the opposite extremity and let the flexed knee fall toward the table. Pain or limitation indicates either hip joint and/or lumbosacral abnormality.
  - d. Extension. While prone, have the examinee arch the back and test strength in extension by noting the degree to which this is possible.
  - e. Abnormal findings. If pain is experienced on back motions in association with these maneuvers or if there is asymmetry or abnormal configuration, back x-rays, including pelvis, should be obtained. These should include antero-posterior, lateral, and oblique views.
15. Identifying Body Marks, Scars, and Tattoos (Item 37 of the Report of Medical Examination, Form DD-2808).
- a. Examination. Carefully inspect the examinee's body, front and rear, on each side of the median line separately, commencing with the scalp and ending at the foot. Record under the "Notes" section on the face of the Report of Medical Examination, Form DD-2808 all body marks, tattoos, and scars useful for identification purposes. Also state if no marks or scars are found.
  - b. Description of Body Marks, Scars, and Tattoos.
    - (1) Indicate the size, location, and character of scars, moles, warts, birthmarks, etc.
    - (2) When recording the location of a tattoo, include narrative description of the design. Tattoo transcriptions of words or initials shall be recorded in capital letters. Describe the size of a tattoo regarding its general dimensions only. A statement relative to color or pigment is not required.
    - (3) Note amputations and losses of parts of fingers and toes showing the particular digit injured and the extent or level of absence.
  - c. Abbreviations for Body Marks, Scars, and Tattoos.
    - (1) The following are authorized abbreviations for the descriptions or conditions indicated:



Amp.- amputation	m. - mole	w. -wart
f. -flat	p. -pitted	VSULA-
fl. -fleshy	r. -raised	vaccination scar
s. -scar smooth	l. -linear	upper left arm
v. -vaccination	o. -operative	h. -hairy

- (2) Combinations of the above abbreviations are permissible: p.s. 1/2d. - pitted scar 1/2 inch diameter, f.p.s. 1x1/2 - flat pitted scar 1 inch long and 1/2 inch wide, r.h.m. 1/4d. - raised hairy mole 1/4 inch diameter.
- (3) Do not use abbreviations when describing tattoos since they are likely to be mistaken as signifying tattooed letters.

16. Neurologic (Item 39 of the Report of Medical Examination, Form DD-2808).  
Conduct a careful neurological examination being attentive to the following:

- a. Gait. The individual shall: walk a straight line at a brisk pace with eyes open, stop, and turn around. Look for spastic, ataxic, incoordination, or limping gait, absence of normal associated movements, deviation to one side or the other, the presence of abnormal involuntary movement, undue difference in performance with the eyes open and closed.
  - (1) Stand erect, feet together, arms extended in front. Look for unsteadiness and swaying, deviation of one or both of the arms from the assumed position, tremors, or other involuntary movements.
  - (2) Touch the nose with the right and then the left index finger, with the eyes closed and both arms extended laterally to a horizontal position. Look for muscle atrophy or pseudohypertrophy, muscular weakness, limitation of joint movement, and spine stiffness.
- b. Pupils. Look for irregularity, inequality, diminished or absent contraction to light or lack of accommodation.
- c. Deep Sense (Romberg). Negative, slightly positive, or pronouncedly positive.
- d. Deep Reflexes: Patellar, Biceps, etc. Record as absent (o), diminished (-), normal (+), hyperactive (++), and exaggerated (+++).
- e. Sensory Disturbances. Examine sensation by lightly pricking each side of the forehead, bridge of the nose, chin, across the volar surface of each wrist, and dorsum of each foot. Look for inequality of sensation right and left. If these sensations are abnormal, vibration sense should be tested at ankles and wrists with a tuning fork. With eyes closed, the examinee shall move each heel down the other leg from knee to ankle. Test sense of movement of great toes and thumb. Look for diminution or loss of vibration and plantar reflexes. When indicated, perform appropriate laboratory tests and x-ray examinations.

- f. Motor Disturbances. Evidence of muscle weakness, paresis, or any other abnormality.
  - g. Muscular Development. Evidence of atrophy, compensatory hypertrophies, or any other abnormality.
  - h. Tremors. State whether fine or coarse, intentional or resting, and name parts affected.
  - i. Tics. Specify parts affected. State whether they are permanent or due to fatigue or nervous tension.
  - j. Cranial Nerves. Examine carefully for evidence of impaired function or paresis. Remember that some of the cranial nerves are subject to frequent involvement in a number of important diseases, such as syphilis, meningitis, encephalitis lethargica, and injuries to the cranium.
  - k. Psychomotor Tension. Test the ability to relax voluntarily by having the examinee rest the forearm upon your palm then test the forearm tendon reflexes with a percussion hammer.
  - l. Peripheral Circulation. Examine for flushing, mottling, and cyanosis of face, trunk, and extremities. Question as to the presence of localized sweating (armpits and palms) and cold extremities. Carefully study any abnormalities disclosed on the neurological examination and express an opinion as to their cause and significance and whether they are sufficient cause for rejection.
17. Psychiatric (Item 40 of the Report of Medical Examination, Form DD-2808).
- a. Personality Evaluation. In order to evaluate the adequacy of the examinee's personality for adjustment to the conditions of military service:
    - (1) Estimate the examinee's capacity coupled with real respect for personality and due consideration for feelings.
    - (2) Conduct the examination in private to encourage open and honest answers.
    - (3) Attempt to discover any difficulties that the examinee may have had with interpersonal relationships at work or during leisure activities.
  - b. Diagnosis of Psychiatric Disorders. The diagnosis of most psychiatric disorders depends upon an adequate longitudinal history, supplemented by information obtained from other sources, such as family, physicians, schools, churches, hospitals, social service or welfare agencies, and courts.
  - c. Telltale Signs of Psychiatric Disorders. Be watchful for any of the following: inability to understand and execute commands promptly and adequately; lack of normal response, abnormal laughter; instability;

seclusiveness; depression; shyness; suspicion; over boisterousness; timidity, personal uncleanliness; stupidity; dullness; resentfulness to discipline; a history of enuresis persisting into late childhood or adolescence; significant nail biting; sleeplessness or night terrors; lack of initiative and ambition, sleep walking; suicidal tendencies; whether bona fide or feigned. Abnormal autonomic nervous system responses (giddiness, fainting, blushing, excessive sweating; shivering or goose flesh; excessive pallor; or cyanosis of the extremities) are also occasionally significant. Note also the lack of responses as might reasonably be expected under the circumstances.

d. Procedures for Psychiatric Examination.

- (1) Mental and personality difficulties are most clearly revealed when the examinee feels relatively at ease. The most successful approach is one of straightforward professional inquiry, coupled with real respect for the individual's feelings and necessary privacy. Matters of diagnostic significance are often concealed when the examinee feels the examination is being conducted in an impersonal manner or without due concern for privacy.
- (2) Pay close attention to the content and implication of everything said and to any other clues, in a "matter-of-fact manner". Follow-up whatever is not self evident or commonplace.

e. Aviation only. Although this phase of the examination is routinely performed only on candidates for flight training, it may be made part of any aviation physical examination. The objective is to determine the examinee's basic stability, motivation, and capacity to react favorably to the special stresses encountered in flying. Report any significant personality change in an experienced aviator. Following the completion of the general examination:

- (1) Study carefully the examinee's family history.
- (2) Determine the family's attitude towards flying and the examinee's reaction to the stresses of life in general and emotional response and control.

18. Endocrine System. Evaluate endocrine abnormalities during the general clinical examination. Palpate the thyroid for abnormality and observe the individual for signs of hyperthyroidism or hypothyroidism. Observe general habitus for evidence of endocrine dysfunction.

19. Dental (Item 43 of the Report of Medical Examination, Form DD-2808).

a. Who May Conduct Dental Examinations.

- (1) For Academy, OCS, and direct commission applicants: a Uniformed Services Dental Officer.

- (2) For all aviation, diving, and overseas/sea duty physical examinations: a Uniformed Services Dental Officer or a contract dentist.
- (3) For all others: a Uniformed Services dental officer, a contract dentist, or a medical examiner if a dentist is unavailable.

b. Procedures for Conducting Dental Examinations.

- (1) Applicants for Original Entry. Whenever practical, applicants for original entry into the Service shall be given a Type II dental examination. Otherwise, the Dental Officer shall determine the type of examination that is appropriate for each examinee.
- (2) Active Duty Personnel. Members on active duty, who are assigned to locations where CG, USMTF, or civilian contract dental clinics are available, shall be required to have an annual Type II dental examination.
- (3) Reserve Personnel.

(a) Type II dental examination is required annually for all SELRES.

[1] Members who are unable to be screened by a CG or DOD Dental Clinic or who do not participate in the TRICARE Dental Plan or have private dental insurance or cannot use the RHRP contract may use a civilian dentist provided they follow HSWL SC direction.

[2] HSWL SC is authorized to provide payment of SELRES dental exams obtained from civilian sources. Payment for dental cleaning and follow-up care is not authorized.

[3] The results from dental exams provided by DOD or civilian dentists shall be submitted on a Department of Defense Active Duty/Reserve Forces Dental Examination, Form DD-2813.

- c. Dental Restorations and Prostheses. The minimum number of serviceable teeth prescribed for entry in various programs of the Service is predicated on having retentive units available to provide for the reception of fixed bridges or partial dentures that may be necessary for satisfactory masticatory or phonetic function. Prostheses already present should be well-designed, functional, and in good condition.

20. Laboratory Findings.

- a. Required Tests. Personnel undergoing physical examinations are required to have the following tests performed, except where obtaining them is not possible or expeditious, or incurring charges for them is not authorized. In such cases, these tests shall be obtained at the first duty station where facilities are available. All Labs must be performed within 180 days of the

physical exam or they will be considered out of date. The normal values listed below are for guidance. Abnormal laboratory values alone are not disqualifying; however, the causative underlying condition may be. Minimal deviations may not require further evaluation and this should be noted as NCD (not considered disqualifying) in Item #74 by the examiner. Normal variants should be noted as such.

b. Hematology/Serology.

(1) Hematology. Perform a hemoglobin (HGB) or hematocrit (HCT) on all examinees. Perform other hematological studies only as indicated.

(a) Hemoglobin - Males 13-18 gm/100ml Females 11.7-16 gm/100ml.

(b) Hematocrit - Males 40-54%, Females 35-47%.

NOTE: If any of these parameters are abnormal, an RBC and indices shall be done. Normal indices are:

RBC-Males	4.3 to 6.2 million
Females	3.8 to 5.4 million
MCV-	82-92 cubic microns
MCH-	27-32 picograms
MCHC -	30-36%

(2) Serological Test for Syphilis (RPR/STS).

(a) No longer required for aviation physicals and diving candidate physicals.

(b) Unless there is a documented history of adequately treated syphilis, all examinees testing positive shall have repeat testing three or more days later. Ensure that at the time of obtaining serum the examinee neither has, nor is convalescing from, any acute infectious disease or recent fever. If available at no charge, the facilities of local or state health departments may be used for performing serological tests. Examinees with a history of treated syphilis should have declining or low titer positive reaction.

(c) If the second test is positive then obtain an FTA/ABS. If the FTA/ABS is positive, further evaluation may be required to determine the appropriate therapy.

(d) Several conditions that are known to give false RPR/STS are infectious mononucleosis, malaria, yaws, pinta, chicken pox, infectious hepatitis, immunization, and atypical pneumonia. The cause of a false positive serological test for syphilis should be explored since many diseases giving a false positive are also disqualifying.

(e) New diagnosis of syphilis requires disease reporting per local governmental requirements and in accordance with Chapter 7-B-3 of this Manual.

- (f) Diagnosis of syphilis requires testing for other sexually transmitted infections (gonorrhea, chlamydia, HIV and Hepatitis B).
- (3) Sickle Cell Preparation Test. Applicants for aviation and diving training shall be tested for sickling phenomenon, if not previously tested. All accessions shall be tested. Evaluate positive sickledex results by a quantitative hemoglobin electrophoresis. Greater than 40 percent Hbs is disqualifying for aviation and diving. Once the test has been completed, the results will be filed in the health record and recorded on the Problem Summary List. This is a one time test that never needs to be repeated and the results shall be filed in the health record.
- (4) Lipid Testing.
  - (a) Lipid screening should be performed based upon the Clinical Preventive Services guidelines as contained in CG Periodic Health Assessment, COMDTINST 6150.3 (series).
- (5) HIV Antibody.
  - (a) All HIV testing should be performed in accordance with the Coast Guard Human Immunodeficiency Virus (HIV) Program, COMDTINST M6230.9 (series).
- (6) Tuberculosis (TB) Surveillance/Screening. CG members are required to have a baseline Tuberculin skin test (TST) or Quantiferon Gold Test (QFT) per the Centers for Disease Control and Prevention (CDC) guidance. No group of CG personnel is at high risk for TB. Individuals whose duties include alien migrant interdiction, marine safety operations, and health care personnel are not at increased risk unless they work in facilities that regularly care for persons with active TB disease. Therefore, periodic screening for TB is not indicated. Members whose last recorded TST reaction was reactive shall be screened during the PHA for indicators of active disease. This involves reviewing the HR and asking the member about the following: persistent and/or productive cough (especially coughing up blood), chest pain, fever, chill, night sweats, appetite loss, and unintended weight loss. Routine evaluation of old TST reactors by chest radiograph is not authorized nor warranted. A Medical Officer may order a TST and/or chest radiograph on a patient with clinical signs/symptoms of active TB or an individual TST on a patient with risk factors listed below:
  - (a) Close contacts of persons known or suspected to have active TB (sharing the same household or other enclosed environments).
  - (b) Foreign-born persons from areas where TB is common (Asia, Africa, Latin America, Eastern Europe, Russia).

- (c) Health care workers who routinely serve the high-risk clients listed above.
  - (d) TST is not required for retirement or separation examinations. Information on how to perform tuberculin skin testing may be found at the following CDC website:  
<http://www.cdc.gov/tb/education/Mantoux/guide.htm>.
- c. Chest X-ray (Item 52 of the Report of Medical Examination, Form DD-2808).
  - (1) Will be accomplished as part of the physical examinations when clinically indicated. Chest X-rays previously performed within eighteen (18) months of application, with normal results, are acceptable if there is no change in clinical presentation.
  - (2) Will not be performed for routine screening purposes without a prior clinical evaluation and a specific medical indication. The Senior Medical Executive may authorize an exception to this policy when there are obvious medical benefits to be gained by routine screening x-ray examination (e.g., Asbestos Medical Surveillance Program). Such exceptions should be authorized only after careful consideration of the diagnostic yield and radiation risk of the x-ray study, as well as other significant or relevant costs or social factors. X-ray examinations will not be ordered solely for medical-legal reasons.
- d. Electrocardiogram (Item 52 of the Report of Medical Examination, Form DD-2808).
  - (1) Electrocardiograms (ECG) shall be accomplished routinely on the following individuals:
    - (a) Those with a medical history or clinical findings are suggestive of cardiac abnormalities.
    - (b) Examinees with a sitting pulse rate of less than 50 or more than 100.
    - (c) Aviation and diving candidates and designated personnel refer to the CG AERO Guide v1.0  
[http://www.uscg.mil/hq/cg1/cg112/cg1122/docs/qiig/QIIG\\_51\\_At\\_t\\_4.pdf](http://www.uscg.mil/hq/cg1/cg112/cg1122/docs/qiig/QIIG_51_At_t_4.pdf)
  - (2) All student and designated aviation personnel shall have an ECG on file in their health record.
  - (3) All tracings will be compared to the baseline reading in the health record, if one is present. If significant changes are present, obtain a cardiac consultation. A report of the consult shall be submitted for



review along with the Report of Medical Examination, Form DD-2808. It is imperative then that proper techniques for recording the ECG be followed.

- (a) The routine ECG will consist of 12 leads, namely standard leads I, II, III, AVR, AVL, AVF, and the standard precordial leads V1 through V6.
  - (b) Take care to properly place the precordial electrodes. It is important that the electrodes across the left precordium are not carried along the curve of the rib but are maintained in a straight line. Be particular in placing the first precordial lead so as to avoid beginning placement in the third interspace rather than the fourth. Do not smear electrode paste from one precordial position to another. Include a standardization mark on each recording.
- e. Urinalysis. A urinalysis is required on all physical examinations. The urine shall be tested for specific gravity, glucose, protein, blood, leukocyte esterase, and nitrite by an appropriate dipstick method. A microscopic examination is required only if any of these dipstick tests is abnormal.
- (1) Specific Gravity. Normal values are 1.005-1.035. Specific gravity varies with fluid intake, time of day, climate, and medication. As a rule, elevation of the specific gravity reflects only the state of hydration, while a low specific gravity may reflect kidney disease. In evaluating abnormalities, a repeat is generally sufficient, provided the factors above are considered and explained to the individual. Where possible, the repeat should be a first morning specimen which is usually the most concentrated.
  - (2) Glucose. Any positive test is abnormal. A false positive for glucose may occur in individuals who take Vitamin C or drink large quantities of fruit juice. As soon as practical after discovery of the glycosuria, obtain a fasting blood glucose. If glycosuria persists or if the fasting blood glucose exceeds 125 mg/100 ml, evaluate the individual for diabetes.
  - (3) Protein. A trace positive protein is often associated with a highly concentrated (specific gravity 1.024 or greater) early morning specimen and is considered normal and need not be repeated. A one plus or greater protein, or a trace positive in the presence of a dilute urine, should be evaluated by a 24-hour specimen (normal range 10-200 mg protein/24 hours).
  - (4) Microscopic.
    - (a) Normal: 0-5 WBC per high power field (hpf)  
0-5 RBC per hpf (clean catch specimen)

Occasional epithelial cells (more may be normal  
in an otherwise normal urinalysis)

No casts occasional bacteria

- (b) Pyuria (WBC >5/hpf) usually indicates an infection or improper collection techniques. Appropriate follow-up is required, including a repeat after the infection has cleared.
  - (c) Hematuria (RBC >5/hpf) may normally occur following heavy exercise or local trauma and as a false positive in menstruating females. It always requires evaluation with the minimum being a repeat showing no hematuria.
  - (d) Casts, heavy bacteria, other organisms, and abnormal cells require further evaluation.
- f. Pap Test (Item 52 a. of the Report of Medical Examination, Form DD-2808).
- (1) The pap test will be performed in the following manner:
    - (a) In accordance with the Clinical Preventive Services guidelines as contained in CG Periodic Health Assessment, COMDTINST 6150.3 (series) (for females who are not obtaining a pre-training examination or are not cadets/recruits).
    - (b) In alignment with the United States Preventive Task Force, the Coast Guard will require initial Pap smears for accessions at the Training Center Cape May and the Coast Guard Academy at age twenty-one. At Training Center Cape May, Pap smears will begin for female recruits who are 6 months prior to twenty-one years of age (due to administrative issues). For cadets, the screening interval will be every other year for those females with normal cytology.
  - (2) Pap tests and pelvic examinations (by civilian or military practitioners) that have been performed within one year of periodic examinations are acceptable. Providers can recommend an annual Pap smear for those individuals at high risk for cervical cancer (e.g., family history) on a case by case basis. In any case, results of the pelvic examination and Pap test will be recorded in Item 52 a. The practitioner is responsible for communicating the result of the Pap smear to the patient. Completion of Pap smears should be recorded in MRRS. MRRS defaults the Pap smear interval to every 3 years. The Health Record Custodian (HRC) should ensure the interval is changed appropriately (e.g, 1 year) for abnormal results requiring more frequent follow-up.

- (3) To reduce false-negative smears, endocervical sampling shall be done using a cytobrush, provided no contraindication is present (as in pregnancy or cervical stenosis). Laboratories to which smears are sent for interpretation must, as a matter of routine, indicate on their reports whether endocervical sampling was adequate. Where endocervical cell sampling is reported as inadequate, the smear shall be repeated.
- g. Pulmonary Function Test (PFT). Perform a PFT on all applicable Occupational Medical Surveillance and Evaluation Program (OMSEP) examinations and when clinically indicated.
- (1) Screening spirometry should not be performed if the subject falls into one of the following categories:
- (a) Is acutely ill from any cause.
  - (b) Has smoked or used an aerosolized bronchodilator within the past hour.
  - (c) Has eaten a heavy meal within the previous two hours.
  - (d) Has experienced an upper or lower respiratory tract infection during the past three weeks.
  - (e) Administer the PFT by following the manufacturers' instructions.

FIGURE 3-C-1

	<b>SPIROMETRIC GUIDELINES</b>	
	<b>OBSTRUCTIVE DISEASE FEV-1/FVC</b>	<b>RESTRICTIVE DISEASE FVC% FVC PREDICTED</b>
<b>NORMAL</b>	> 0.69	> .80
<b>MILD TO MODERATE</b>	0.45 -0.69	0.51-0.80
<b>SEVERE</b>	< 0.45	<0.51

- h. Special Tests. In some cases, information available should be supplemented by additional tests or diagnostic procedures (eye refractions, x-rays, repeated blood pressure readings, etc.), in order to resolve doubts as to whether the examinee is or is not physically qualified. If facilities are available to perform such tests at no cost, they should be obtained as indicated in individual cases. Otherwise, applicants for original entry in the Service will

be required to obtain such tests at their own expense, if they desire further consideration.

- i. Laboratory Values (OMSEP). All laboratory values not previously discussed but that accompany a physical examination (e.g., chemistry profiles, etc.,) must have accompanying normals for the laboratory that performed the tests.
- j. Mammography. Breast cancer screening via mammography should be performed in accordance with the Clinical Preventive Services guidelines as continued in CG Periodic Health Assessment, COMDTINST 6150.3 (series). Results should be documented on the routine physical exams. Mammograms done between the required screening ages can be used to satisfy the periodic requirement. This judgment is left to the practitioner. If mammography is not done at the required ages, the reason must be supplied in Item #73 of the Report of Medical Examination, Form DD-2808 and should include date and result of the last mammogram. Practitioners are responsible for communicating mammography results (either positive or negative) to the patient.
- k. Glucose-6-Phosphate Dehydrogenase (G-6-PD). Qualitative testing (present or not) for G-6-PD deficiency is required for all AD and SELRES members. The results of testing shall be annotated on the Adult Preventive and Chronic Care Flowsheet, Form DD-2766 as well as in MRRS. Once testing is accomplished, it need never be repeated.

21. Height, Weight, and Body Build.

- a. Height. Measure the examinee's height in both meters and to the nearest inch, without shoes.
- b. Weight.
  - (1) Weights are preferred in underwear/undergarments only. Individuals may be weighed in uniform with the adjustment for clothing as stipulated in the Coast Guard Weight and Body Fat Standards Program Manual, COMDTINST M1020.8 (series).
  - (2) Weigh the examinee on a standard set of scales calibrated and accurate. Record the weight both kilograms and pounds. Do not record fractions of pounds, such as ounces.
- c. Frame Size. Using a cloth tape, measure the wrist of the dominant hand, measure all the way around from lateral to medial styloid process. Measure in centimeters and inches including fraction of inches.
- d. Body Mass Index (BMI). Apply standard BMI scale using height/weight.

22. Distant Visual Acuity and Other Eye Tests.

- a. Distant Visual Acuity, General. Visual defects are one of the major causes for physical disqualification from the armed services. Methods of testing vision have varied greatly among the armed services and from place to place in each Service. Consequently, visual test results are not always comparable. An examinee presenting for examination at one place might be qualified for visual acuity, while at another place, disqualified. Although this is an undesirable situation, no practical solution, such as prescribing standards for equipment and conditions (room size, ventilation, paint colors, room illumination, etc.), is available to the CG as the examinations are obtained from various sources over which the CG has no control. It is therefore imperative that examiners be especially painstaking to obtain the most accurate results possible.
- b. Examination Precautions.
  - (1) Make every effort to conduct the examination when the examinee is in normal physical condition. Follow the examination routine in the order prescribed in the following instructions. Record the vision for each eye when determined so that errors and omissions will be avoided.
  - (2) It may be extremely difficult to obtain an accurate measure of visual acuity. Bear in mind those individuals who are anxious to pass visual acuity tests may resort to deception. Similarly, other individuals may attempt to fail a visual acuity test to avoid undesirable duties. Hence, be prepared to cope with either possibility in order to uncover and recognize visual defects without the cooperation of the person being tested.
  - (3) Refer uncooperative examinees to a Medical Officer.
- c. Examination Procedures.
  - (1) In order to obtain a more valid evaluation, inform examinees that contact lenses will not be worn during the evaluation and for 72 hours before. Orthokeratotic lenses shall be removed for 14 days or until vision has stabilized for 3 successive examinations.
  - (2) If the examinee wears glasses, they must be removed before entering the exam room. Test each examinee without unnecessary delay after entering the examining room. In order to prevent personnel from memorizing the charts, permit only one examinee to view the test charts at a time. Ensure other examinees cannot hear the examination.
  - (3) Follow manufactures instructions on how to conduct a visual acuity test for the piece of equipment you are using. Visual acuity may also be determined with the Armed Forces Vision Tester (AFVT). Follow manufactures instruction on how to administer this test.

- d. Score recording. Record vision test scores as a fraction in that the upper number is the distance in feet from the chart and the lower number is the value of the smallest test chart line read correctly. Thus, a person reading at a distance of 20 feet, the 30 foot test chart line is given a score of 20/30. 20/20 indicates that a person reads at a distance of 20 feet the test chart line marked 20. Similarly, 20/200 means a person can read at a distance of 20 feet only the test chart line marked 200.
- e. Refraction.
  - (1) Eye refractions are required:
    - (a) When applying for flight training [Student Naval Aviator (SNA) pilot candidates]. (This must include cycloplegic.).
    - (b) When visual acuity falls below 20/20 in either eye (near or distant).
  - (2) Subsequent refractions are required only if the visual acuity deteriorates further.
  - (3) If a cycloplegic is used during the course of refraction, then the examinee should wear dark glasses until the effects disappear. The installation of 1 drop into each eye of 1% solution of pilocarpine hydrochloride in distilled water after completing the examination will constrict the pupil and thus relieve the photophobia.
- f. Near Vision. Test near vision on all examinees and record results in Item 61 of the Report of Medical Examination, Form DD-2808 using Snellen notations. The examinee should be positioned so that the light source is behind him/her and the near vision test card is well illuminated. See manufacturer's instructions on how to administer the test. Record near vision both with and without corrective lenses if glasses are worn or required. Record corrections worn in Item 73. See the chart below for conversion from the various near point letter nomenclatures to Snellen notations.

Table 3-C-1

**CONVERSION TABLE FOR VARIOUS NEAR POINT LETTER  
NOMENCLATURE**

<b>Standard Test Chart</b>	<b>Snellen English Linear</b>	<b>Snellen Metric</b>	<b>Jaegar</b>
14/14	20/20	0.50	J-1
14/17.5	20/25	.62	J-2
14/21	20/30	.75	J-4
14/28	20/40	1.00	J-6
14/35	20/50	1.25	J-8
14/49	20/70	1.75	J-12
14/70	20/100	2.25	J-14
14/140	20/200		

g. Heterophoria.

- (1) Except for aviation personnel, special tests for heterophoria are not required unless medically indicated.
- (2) Heterophoria is a condition of imperfect muscle balance in which the eyes have a constant tendency to deviate and latent deviation is overcome by muscular effort (fusion to maintain binocular single vision). Fusion is responsible for the two eyes working together in harmony and when anything prevents this, fusion is disrupted and one eye deviates. Since heterophoria is only a tendency of the eyes to deviate, no actual deviation is apparent when the eyes are being used together under ordinary conditions. The deviation becomes visible only when fusion control is weakened or abolished. When deviation occurs, its exact amount can be estimated with some accuracy by neutralizing the deviation with prisms of varying strength. If the eye deviates toward its fellow, the deviation is known as esophoria; if it deviates away from its fellow, the deviation is known as exophoria; if it deviates up or down, the deviation is known as hyperphoria. The condition of perfect muscle balance (no deviation) is orthophoria.
- (3) The vertical and horizontal phorias may be tested with the Phoropter or AFVT.



- h. Accommodation. There is no requirement to test accommodation unless medically indicated.
- i. Color Perception Tests. Examinees are qualified if they pass either the Pseudoisochromatic Plates (PIP) or the Farnsworth Lantern (FALANT) test. The testing for color vision must be unaided or with standard corrective lenses only. Use of any lenses (such as Chromagen) or other device to compensate for defective color vision is prohibited. Examinees may be found qualified, "on record", if a previous certified physical examination has a passing PIP or FALANT score available for review. Exception: At the time of accession medical screening (e.g. CG Academy (including cadets and OCS candidates), Cape May recruits) the PIP color vision test will be repeated and normal color vision confirmed under controlled conditions as described below. Examinees failing the PIP will be administered the FALANT test. Examinees who fail the PIP are qualified if they pass the FALANT.

(1) Farnsworth Lantern Test (FALANT).

(a) Administration and Scoring.

- [1] Instruct the examinee: "The lights you will see in this lantern are either, red, green, or white. They look like signal lights at a distance. Two lights are presented at a time--in any combination. Call out the colors as soon as you see them, naming first the color at the top and then the color at the bottom. Remember, only three colors--red, green, and white--and top first".
- [2] Turn the knob at the top of the lantern to change the lights; depress the button in the center of the knob to expose the lights. Maintain regular timing of about two seconds per exposure.
- [3] Expose the lights in random order, starting with RG or GR combinations (Nos. 1 or 5), continuing until each of the 9 combinations have been exposed.
- [4] If no errors are made on the first run of nine pairs of lights, the examinee passes.
- [5] If any errors are made on the first run, give two more complete exams with one done in the opposite direction (to prevent memorization). Passing score is at least 16 out of 18 correct for the two runs.

- [6] An error is considered the miscalling of one or both of a pair of lights; if an examinee changes responses before the next light is presented, record the second response only.
- [7] If an examinee uses glasses for distance, they shall be worn.
- [8] If an examinee says "yellow," "pink," etc., state, "There are only 3 colors--red, green, and white".
- [9] If an examinee takes a long time to respond, state, "As soon as you see the lights call them".

(b) Operation of Lantern.

- [1] Give the test in a normally lighted room, screen from glare, exclude sunlight. The examinee should face the source of room illumination.
- [2] Test only one examinee at a time (do not allow others to watch).
- [3] Station the examinee 8 feet from the lantern.
- [4] The examinee may stand or sit, tilt the lantern so that the aperture in the face of the lantern is directed at examinee's head.

(2) Pseudoisochromatic Plates (PIP). When Pseudoisochromatic Plates are used to determine color perception, a color vision test lamp with a daylight filter or a fluorescent light with a daylight tube shall be used for illumination. Do not allow the examinee to trace the patterns or otherwise touch test plates. Show the plates at a distance of 30 inches and allow 2 seconds to identify each plate. If the examinee hesitates, state "read the numbers." If the examinee fails to respond, turn to the next plate without comment. Qualification is ascertained as follows:

- (a) 20 plate test set. Examinee must correctly read at least 17, excluding demonstration plates.
- (b) 18 plate test set. Examinee must correctly read at least 14 excluding demonstration plates.
- (c) 15 plate test set (one demo). Examinee must correctly read 10 plates.

j. Depth Perception. Depth perception may be determined by the Armed Forces Vision Tester (AFVT) or OPTEC 2300, the Random Dot Circles Test (RANDOT), or the Titmus Graded Circles Stereo Acuity Test

(TITMUS). When doing a physical on the Report of Medical Examination, Form DD-2808, if you do not use the AFVT, line through the pre-printed entry and record the test used with the proper score. If you use the AFVT and then also use another depth perception test, record the AFVT in block 67 and then record the additional depth perception test findings in block 60 (other vision test) or block 73 (notes). Required for all aviation personnel and when medically indicated.

- (1) If the AFVT or OPTEC 2300 is used, have the patient seated comfortably. If the patient wears a habitual spectacle prescription they may be tested without the prescription, but if they fail, retest with the prescription. Test emulates distance test (optical infinity). Refer to manual for correct settings for model being used. The following guidelines must be adhered to when testing:
  - (a) Group A is for demonstration purposes only and should not be used as part of the actual test (see manual).
  - (b) Group B is at the level of the new overall standard of 40 seconds of arc, there are three presentations of five circles each within group b. The patient identifies the circle within each presentation that appears "closest".
  - (c) Patient must correctly identify all presentations within group b to pass.
  - (d) You may test beyond group b if desired but it is not necessary. Record as "AFVT group b - pass".
  - (e) If patient fails any in the group, retest using RANDOT and/or Titmus below.
- (2) RANDOT. If the patient wears habitual spectacle prescription they may test without the prescription, but if the patient fails, retest with the prescription. Polaroid spectacles may also be worn (over habitual prescription if requested). Test distance is 40 cm (16 inches). Provide adequate light but avoid reflections from the tests surface. Hold test upright to maintain the proper axis of polarization. Do not permit the patients head to tilt during testing. The following guidelines must be adhered to when testing:
  - (a) There are ten presentations of three circles each in the RANDOT, you must test all ten presentations, do not stop after number seven.
  - (b) You must test all presentation in order, do not jump around since each level is progressively more difficult.
  - (c) Patient identifies the circle that appears "closest".
  - (d) Test until the patient misses two levels in a row.
  - (e) Record the last level passed successfully.

- (f) For RANDOT, a minimum passing score is correctly identifying presentations 1 through 7 which equal 40 seconds of arc.
  - (g) Record as the number missed over the number possible. For example, "RANDOT 3/10 pass" or "RANDOT 4/10 fail".
  - (h) If the patient fails the RANDOT, the patient may be retested using AFVT / OPTEC 2300 or TITMUS.
- (3) TITMUS. If the patient wears habitual spectacle prescription they may test without the prescription, but if they fail, retest with the prescription. Polaroid spectacles may also be worn (over habitual prescription if requested). Test distance is 40 cm (16 inches). Provide adequate light but avoid reflections from the tests surface. Hold test upright to maintain the proper axis of polarization. Do not permit the patients head to tilt during testing. The following guidelines must be adhered to when testing:
  - (a) There are nine presentations of four circles each in the Titmus.
  - (b) You must test all nine presentations.
  - (c) You must test all presentations in order. Do not jump around since each level is progressively more difficult.
  - (d) Patient identifies the circle that appears "closest".
  - (e) Test until the patient misses two levels in a row (or the last presentation).
  - (f) Record the last level passed successfully.
  - (g) For Titmus, a minimum passing score is correctly identifying all of the presentation 1 through 9 which equals 40 seconds of arc.
  - (h) Record the number missed over the number possible. For example "Titmus 0/9 PASS" or "1/9 FAIL"
- k. Field of Vision. Except for aviation personnel, special tests for field of vision are not required unless medically indicated. Exact procedures on how to perform this test can be obtained from the HS required references.
- l. Night Vision. A test for night vision (dark adaptation) is not required unless indicated for medical or special reasons.
- m. Red Lens Test. The red lens test is required on DODMERB examinations and when medically indicated. See manufactures instruction on how to perform this test.

n. Intraocular Tension.

- (1) General. Determine intraocular tension each time an eye refraction is performed, during all annual physical examinations, all aviation physicals, and when medically indicated. Above normal tension is a sign of glaucoma; below normal tension of ten exists in degenerated eyeballs or as a normal finding; alterations in tension are sometimes found in cyclitis. Questionable findings on palpation and ophthalmoscopic examination shall be further evaluated.
- (2) Testing Intraocular Tension.
  - (a) General. Routine tonometry shall be performed by a Medical Officer, optometrist, or a technician who has received instruction in properly performing and interpreting this test.
  - (b) Instrument. The tonometer estimates the intraocular pressure (IOP) or tension within the eyeball.
  - (c) Precaution. Determine intraocular tension after all other eye examinations have been completed. Because of corneal denuding by tonometric measurement, a refraction (cycloplegic or manifest) shall not be performed for at least 24 hours following this procedure.
  - (d) Readings. Intraocular pressure consistently above 21mm Hg in either eye or a difference of 4 or more between the two eyes, shall be referred for ophthalmologic evaluation.

23. Audiometer.

- a. An audiometric examination is required on all physical examinations using frequencies 500, 1000, 2000, 3000, 4000, and 6000 hertz.
- b. Obtain reference audiograms on all personnel upon initial entry into the CG at recruit training and all officer accession points (Academy, OCS, Direct Commission, etc.), and at first duty station for all others.

24. Psychological and Psychomotor. Psychological and psychomotor testing is not required unless medically indicated.

FIGURE 3-C-2

The following chart enumerates certain conditions, defects, and items of personal history that require thorough evaluation and sets forth the special test, examination, or report desired in each instance.

ITEM: DESIRED:	EXAMINATION AND INFORMATION
ALBUMINURIA, findings of	Repeat test on a second specimen. If still positive do a quantitative 24 hr urine protein.
ASTHMA history of,	Detailed report of asthma and other allergic conditions and a statement from cognizant physician on (1) number and approximate dates of attacks of asthmatic bronchitis or other allergic manifestations; (2) signs, symptoms, and duration of each attack; (3) type and amount of bronchodilating drugs used, and history of any attacks requiring hospitalization.
BACKACHE, back injury	Current orthopedic consultation and report on or wearing of back strength, stability, mobility, and functional brace, history of capacity of back. Report of appropriate x-rays. Transcript of any treatment from cognizant physician.
BLOOD PRESSURE, elevated	Repeat blood pressure (all positions) a.m. and p.m. for 3 consecutive days. Prolonged bed rest shall not precede blood pressure determinations.
CONCUSSIONS	See Head Injury
CONVULSIONS OR SEIZURE	Neurological consultation and electroencephalogram. Transcript of any treatment from cognizant physician.
DIABETES, family history of parent, sibling, or more than on grandparent.	Fasting glucose and Hemoglobin A1C (glycosylated hemoglobin) (normal diet with 10-12 but less than 16 hours fast). If glucose is elevated, repeat and include 2 hr post prandial.
DIZZINESS or FAINTING SPELLS, history of	Neurological and Cardiology consultation
ENURESIS or history of into late childhood or adolescence (age 12)	Comment on applicant's affirmative reply to question "bed wetting" to include number of past incidents and age at last episode. Urologic consultation.
FLATFOOT, symptomatic	Current orthopedic consultation with history. Detailed report on strength, stability, mobility, and functional capacity of foot. Report of appropriate x-rays.
GLYCOSURIA, finding or History	See Diabetes.

FIGURE 3-C-2 (cont.)

HAY FEVER, history of	Detailed report of hay fever and other allergic conditions and a statement from personal physician on (1) number, severity, and duration of attacks of hay fever or any other allergic manifestations, and (2) type and amount of drugs used in treatment thereof.
HEADACHES, frequent or severe, history of	Neurological consultation.
HEAD INJURY with loss of consciousness in past 5 years, history of	Neurological consultation; clinical abstract of treatment from physician.
HEMATURIA, history of or finding of	Medical consultation with evaluation report, including appropriate laboratory studies and/or complete urological evaluation if indicated.
HEPATITIS, history of	Serum Bilirubin, SGOT, SGPT, SGT, Anti-HCV, and HB <sub>s</sub> Ag. Gastroenterology consultation of chronic/active.
JAUNDICE, history of in past 5 years	Serum Bilirubin, SGOT, SGPT, and SGT.
JOINT, KNEE, internal derangement, history of	Current orthopedic consultation and report of strength, stability, mobility, and functional capacity of knee. Report of appropriate radiologic studies together with comparative measurement of the thighs, knees, and legs.
JOINT, SHOULDER, dislocation, history of	Current orthopedic consultation and report on strength, stability, mobility, and functional capacity of shoulder. Report of appropriate radiologic studies.
MALOCCLUSION, TEETH, history of	Report of examination by a dentist with comment as to whether incisal and masticatory function is sufficient for satisfactory ingestion of the ordinary diet, statement as to presence and degree of facial deformity with jaw in natural position and clarity of speech.
MASTOIDECTOMY, bilateral, history of audiogram.	Current ENT consultation to include audiogram.
MOTION SICKNESS, history of	Detailed report of all occurrences of motion sickness (such as air, train, sea, swing, carnival-ride), and the age at the time of the last occurrence.
NASAL POLYPS, history of	ENT consultation, with comment as to date polyps removed if no longer present. Detailed report by physician on allergic history and manifestation to include required medication.
SKULL FRACTURE, in past 5 years, history of	See Head Injury.



FIGURE 3-C-2 (cont.)

SLEEPWALKING, beyond  
childhood, history of  
(age 12)

Detailed comment by physician. Comment on applicant's affirmative reply to question "been a sleepwalker" to include number of incidents and age at last episode.

SQUINT (cross eyed)

Examination for degree of strabismus and presence of complete and continuous 3rd degree binocular fusion. Request completion of Report of Medical Examination, Form DD-2808 Items 62 and 65 and notation of degree of strabismus. Ophthalmology consultation.

STUTTERING or,  
STAMMERING

Report of Reading Aloud Test in Section 3-C-2.

VERTEBRA, fracture or  
dislocation, history of

Current orthopedic consultation and report on strength, stability, mobility, and functional capacity of spine. Report of appropriate radiological studies.

Figure 3-C-3  
HEIGHT STANDARDS

Category	Minimum (cm/inches)	Maximum (cm/inches)
<b>AVIATION PERSONNEL:</b>		
Candidate for Flight Training	<u>157.4/62</u>	<u>198/78</u>
Pilot	<u>157.4/62</u>	<u>198/78</u>
Aircrew Candidate	<u>152.5/60</u>	<u>198/78</u>
Designated Aircrew	<u>152.5/60</u>	<u>198/78</u>
<b>ENLISTED PERSONNEL:</b>		
Enlistment in USCG	<u>152.5/60</u>	<u>198/78*</u>
Enlistment in USCG Reserve	<u>152.5/60</u>	<u>198/78*</u>
<b>CANDIDATES FOR:</b>		
USCG Academy	<u>152.5/60</u>	<u>198/78*</u>
Officer Candidate School	<u>152.5/60</u>	<u>198/78*</u>
Appointment of Licensed Officers of U.S. Merchant Marines in the USCG	<u>152.5/60</u>	<u>198/78*</u>
Direct Commission in USCG	<u>152.5/60</u>	<u>198/78*</u>

- MAXIMUM HEIGHTS WAIVERABLE TO 203 CM/ 80 INCHES BY  
COMMANDER PERSONNEL SERVICE CENTER (PSC-adm-1)

NOTES:

1. Heights are without shoes.
2. Metric conversion: 1 inch = 2.54 cm

Figure 3-C-4

## MINIMUM DISTANT VISUAL ACUITY REQUIREMENTS

CATEGORY	VISION	
A. <u>Aviation Personnel:</u>	<u>Uncorrected</u>	<u>Corrected</u>
1. Candidates for Flight Training	20/50	20/20
2. Pilot, Class	20/200	20/20
3. Pilot, Class 1R	(as waived)	20/20
4. Flight Surgeon, Aviation Medical Examiner or Aviation Mission Specialist	20/400	20/20
5. Candidate for Aircrew	20/100	20/20
6. Designated Aircrew	20/200	20/20
7. Landing Signal Officer (LSO)	20/200	20/20
8. Air Traffic Controller Candidate	20/100	20/20
9. Designated Air Traffic Controller	20/200	20/20
B. <u>Officers</u> (Note 1):		
1. Commissioned or Warrant in the USCG or USCGR	20/400	20/20
2. Appt in the USCG of Licensed Officers of the Merchant Marine	20/400	20/20
3. Direct Commission in the USCGR	20/400	20/20
4. Appointment as Cadet	20/400	20/20
5. Precommissioning of Cadets	20/400	20/20
6. OCS Candidates	20/400	20/20
7. Precommissioning of Officer Candidates	20/400	20/20
8. Diving Candidates	20/100	20/20
9. Designated Diver	20/200	20/20
C. <u>Enlisted Personnel:</u>		
1. Enlistment in the USCG or USCGR	See 3.D.9	(Note 2)
2. Diving Candidates	(Note 3)	20/20
3. Designated Diver	(Note 3)	20/20

Notes:

1. Refractive error does not exceed plus or minus 8.0 diopters spherical equivalent (sphere + 1/2 cylinder) and that astigmatism does not exceed 3.00 diopters and anisometropia does not exceed 3.50 diopters.
2. Corrected vision shall be 20/40 in the better eye and 20/70 in the other or 20/30 in the better eye and 20/100 in the other, or 20/20 in the better and 20/400 in the other. (Note that near visual acuity must correct to at least 20/40 in the better eye.) Refractive error does not exceed plus or minus 8.00 diopters spherical equivalent (sphere + 1/2 cylinder) and ordinary spectacles do not cause discomfort by reason of ghost images, prismatic displacement, etc.; error must not have been corrected by orthokeratology or keratorefractive surgery.
3. 20/100 in the better eye and 20/200 in the worse eye.

D. Medical Standards for Appointment, Enlistment and Induction in the Armed Forces.

1. Scope. This section applies to the Office of the Secretary of Defense, the Military Departments (including the CG at all times; including when it is a service in the Department of Homeland Security by agreement with that Department); the United States Merchant Marine Academy by agreement with the Secretary of Commerce, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands; the Office of the Inspector General of the Department of Defense; the Defense Agencies, the DoD Field Activities; and all other organizational entities in the DoD (hereinafter referred to collectively as the “DOD Components”). The term “Armed Forces,” as used herein, refers to the Army, Navy, Air Force, Marine Corps, and the CG.
2. Medical Standards. This section establishes medical standards, which if not met, are grounds for rejection for military service. Other standards may be prescribed for a mobilization for a national emergency. The medical standards in this section apply to the following personnel:
  - a. Applicants for appointment as commissioned or warrant officers in the active and reserve components.
  - b. Applicants for enlistment in the Armed Forces. For medical conditions or defects predating original enlistment, these standards apply to enlistees’ first six (6) months of active duty.
  - c. During training. Applicants for enlistment in the Reserve and federally recognized units or organizations of the National Guard. For medical conditions or defects predating original enlistment, these standards apply during the enlistees’ initial period of active duty for training until their return to Reserve or National Guard units.
  - d. After 12 months. Applicants for reenlistment in Regular and Reserve components and in federally recognized units or organizations of the National Guard when after a period of more than twelve (12) months have elapsed since discharge.
  - e. Schools. Applicants for the Scholarship or Advanced Course Reserve Officers Training Corps (ROTC), and all other Armed Forces’ special officer personnel procurement programs.
  - f. Retention of cadets and midshipmen at the U.S. Service Academies and students enrolled in ROTC scholarship programs.
  - g. Individuals on the Temporary Disability Retired List (TDRL). Individuals on the TDRL who have been found fit on reevaluation and wish to return to active duty. The prior disabling condition(s) and any other medical conditions

identified before placement on the TDRL, that shall not have prevented reenlistment, are exempt from this Instruction.

- h. All individuals being inducted into the Armed Forces.

3. Policy.

- a. International Classification of Disease (ICD) codes. It is CG policy, by agreement with Medical Standards for Appointment, Enlistment, or Induction in the Military Services, DoD Directive 6130 (series), to utilize the ICD codes in this Section, in all records pertaining to a medical condition that results in a personnel action, such as separation or medical waiver. In addition, when a medical condition standard is waived or results in a separation, written clarification of the personnel action should be provided using standard medical terminology.
- b. Standards. The standards in this section shall be for the acquisition of personnel in the programs in 3.D.2 of this Manual.
- c. Disqualifying standards. Unless otherwise stipulated, the conditions listed in this section are those that would be disqualifying by virtue of current diagnosis, or for which the candidate has a verified past medical history. The medical standards for appointment, enlistment or induction into the Armed Forces are classified by the following general systems.

4. Responsibilities of Commandant (CG-11).

- a. Review CG policies. Review CG policies to conform with the standards contained in DoD Directive 6130 (series) Physical Standard for appointment.
- b. Recommend changes. Recommend to the Office of the Assistant Secretary of Defense (Health Affairs) [OASD (HA)] suggested changes in the standards after service coordination has been accomplished.
- c. Review all the standards on a quinquennial basis. Review all the standards on a quinquennial basis and recommend changes to the OASD (HA). This review will be initiated and coordinated by the DoD Medical Examination Review Board.
- d. Implement standards. Ensure that implementation of the standards in this section are accomplished throughout the U.S. Military Entrance Processing Command.
- e. Direct clinics. Under the provisions of DoD Directive 6130 (series), Medical Standards for Appointment, Enlisted or Induction, direct the clinics to apply and uniformly implement the standards contained in this section.

- f. Authorize waivers. Commandant (CG-11) delegates to CG PSC and the CG Recruiting Command the authority to implement waiver procedures that ensures the uniform application of appointment, enlistment, induction and retention standards.
  - g. Authorize changes in visual standards. Authorize the changes in Service-specific visual standards (particularly for officer accession programs) and establish other standards for special programs. Notification of any proposed changes in standards shall be provided to the ASD (HA) at least 60 days before implementation.
  - h. Ensure that accurate ICD codes are assigned. Ensure that accurate ICD codes are assigned to all medical conditions resulting in a personnel action, such as separation, waiver, or assignment limitation, and that such codes are included in all records of such actions.
  - i. Eliminate inconsistencies and inequities based on race, sex, or examination location in the application of these standards by the Armed Forces.
5. Height. The causes for rejection for appointment, enlistment, and induction in relation to height standards are established by each of the military services. Height standards for the CG are:
- a. Men: Height below 152.5 cm (60 inches) or over 198 cm (78 inches).
  - b. Women: Height below 152.5 cm (60 inches) or over 198 cm (78 inches).
6. Weight. The causes for rejection for appointment, enlistment, and induction in relation to weight standards are contained in Weight /Physical Fitness Standards for CG Military Personnel, COMDTINST M1020.8 (series).
7. Head.
- a. Deformities of the skull, face, or mandible (738.19, 744.9, 754.0) of a degree that shall prevent the individual from the proper wearing of a protective mask or military headgear.
  - b. Loss, or absence of the bony substance of the skull (756.0 or 738.19) not successfully corrected by reconstructive materials, or leaving any residual defect in excess of one (1) square inch (6.45 square centimeters), or the size of a 25-cent piece.
8. Eyes.
- a. Lids.
    - (1) Current symptomatic Blepharitis (373.0x).
    - (2) Current Blepharospasm (333.81).

- (3) Current Dacryocystitis, acute (375.32), or chronic (375.42).
  - (4) Defect or deformity of the lids or other disorders affecting eyelid function (374.4x, 374.50, 374.85, 374.89, 743.62), complete, or significant ptosis (374.3x, 743.61), sufficient to interfere with vision or impair protection of the eye from exposure.
  - (5) Current growths or tumors of the eyelid (173.1, 198.2, 216.1, 232.1, 238.8, 239.89), other than small, non-progressive, asymptomatic, benign lesions.
- b. Conjunctiva.
- (1) Current acute or chronic conjunctivitis (372.1x, 077.0). Seasonal allergic conjunctivitis (372.14) does meet the standard.
  - (2) Current Pterygium (372.4x) if condition encroaches on the cornea in excess of three (3) millimeters, interferes with vision, is progressive, or a history of recurrence after any prior surgical removal (372.45).
- c. Cornea.
- (1) Corneal dystrophy or degeneration of any type (371.x), including but not limited to keratoconus (371.6x) of any degree.
  - (2) History of refractive surgery, including but not limited to, partial or full thickness corneal transplant, radial keratotomy (RK), astigmatic keratotomy (AK), or corneal implants (Intacts).
  - (3) Corneal refractive surgery performed with an excimer laser, including but not limited to photorefractive keratectomy (PRK) (HCPCS S0810), laser epithelial keratomileusis (LASEK), and laser-assisted in situ keratomileusis (LASIK) (HCPCS S0900) (ICD-9 code for each is P11.7) if any of the following conditions are met:
    - (a) Pre-surgical refractive error in either eye exceeded a spherical equivalent of +8.00 or -8.00 diopters.
    - (b) Pre-surgical astigmatism exceeded 3.00 diopters.
    - (c) For corneal refractive surgery, at least 180 days recovery period has not occurred between last refractive surgery or augmenting procedure and accession medical examination.
    - (d) There have been complications and/or medications or ophthalmic solutions, or any other therapeutic interventions such as sunglasses, are required.
    - (e) Post-surgical refraction in each eye is not stable as demonstrated by at least two (2) separate refractions at least one (1) month apart, with initial refraction at least 90 days post-procedure, and the most recent of



which demonstrates more than +/- 0.50 diopters difference for spherical vision and/or more than +/- 0.50 diopters for cylinder vision.

- (4) Current or recurrent keratitis (370.xx).
  - (5) Documented herpes simplex virus keratitis (054.42, 054.43).
  - (6) Current corneal neovascularization, unspecified (370.60), or corneal opacification (371.00, 371.03) from any cause that is progressive or reduces vision below the standards prescribed.
  - (7) Current or history of Uveitis or Iridocyclitis (364.00 – 364.3).
- d. Retina.
- (1) Current or history of any abnormality of the retina (361.00-362.89, 363.14- 363.22), choroid (363.00-363.9), vitreous (379.2x).
- e. Optic Nerve.
- (1) Any current or history of optic nerve disease (377.3), including but not limited to optic nerve inflammation (363.05), optic nerve swelling, or optic nerve atrophy (377.12, 377.14).
  - (2) Any optic nerve anomaly.
- f. Lens.
- (1) Current Aphakia (379.31, 743.35), history of lens implant (V45.61, V43.1) (CPT 66982-66986), or current or history of dislocation of a lens (379.32-379.34, 743.37).
  - (2) Current or history of opacities of the lens (366.xx), including cataract (366.9).
- g. Ocular Mobility and Motility.
- (1) Current or recurrent Diplopia (368.2).
  - (2) Current nystagmus (379.5x) other than physiologic "end-point nystagmus."
  - (3) Esotropia (378.0x), exotropia (378.1x), and hypertropia (378.31): For entrance into Service academies and officer programs, the individual Military Services may set additional requirements. The Military Services shall determine special administrative criteria for assignment to certain specialties.

h. Miscellaneous Defects and Diseases.

- (1) Current or history of abnormal visual fields (368.9) due to diseases of the eye or central nervous system (368.4x), or trauma.
- (2) Absence of an eye (V43.0, V45.78), clinical anophthalmos, unspecified congenital (743.00) or acquired, or current or history of other disorders of globe (360.xx).
- (3) Current unilateral or bilateral exophthalmoses (376.21-376.36).
- (4) Current or history of glaucoma (365.xx), ocular hypertension, pre-glaucoma (365.0-365.04), or glaucoma suspect.
- (5) Any abnormal pupillary reaction to light (379.4x) or accommodation (367.5x).
- (6) Asymmetry of pupil size greater than 2mm.
- (7) Current night blindness (264.5, 368.6x).
- (8) Current or history of intraocular foreign body (360.50-360.69, 871.x).
- (9) Current or history of ocular tumors (190.0, 190.8-190.9, 198.4, 224.0, 224.8-224.9, 234.0, 238.8, 239.89, V10.84).
- (10) Current or history of any abnormality of the eye (360) or adnexa (376, 379.9), not specified in subparagraphs 8.h.(1)-(9), which threatens vision or visual function (V41.0-V41.1, V52.2, V59.5).

9. Vision.

- a. Current distant visual acuity of any degree that does not correct with spectacle lenses to at least one of the following (367):
  - (1) 20/40 in one eye and 20/70 in the other eye (369.75).
  - (2) 20/30 in one eye and 20/100 in the other eye (369.75).
  - (3) 20/20 in one eye and 20/400 in the other eye (369.73).
- b. Current near visual acuity of any degree that does not correct to 20/40 in the better eye (367.1-367.32).
- c. Current refractive error [(hyperopia (367.0), myopia (367.1), astigmatism (367.2x)] in excess of -8.00 or +8.00 diopters spherical equivalent or astigmatism in excess of 3.00 diopters.

- d. Any condition requiring contact lenses for adequate correction of vision, such as corneal scars and opacities (370.0x) and irregular astigmatism (367.22).
- e. Color vision (368.5x) requirements shall be set by the individual Services.

10. Ears.

- a. Current atresia of the external ear (744.02) or severe microtia (744.23), congenital or acquired stenosis (380.5x), chronic otitis externa (380.15-380.16, 380.23), or severe external ear deformity (380.32, 738.7, 744.01, 744.3) that prevents or interferes with the proper wearing of hearing protection.
- b. Current or history of Ménière's Syndrome or other chronic diseases of the vestibular system (386.xx).
- c. History of cochlear implant.
- d. Current or history of cholesteatoma (385.3x).
- e. History of any inner (P20) (CPT 69801-69930) or middle (P19) (CPT 69631-69636, 69676) ear surgery excluding successful tympanoplasty (CPT 69635) performed during the preceding 180 days
- f. Current perforation of the tympanic membrane (384.2x) or history of surgery to correct perforation during the preceding 180 days (P19) (CPT 69433, 69436, 69610, 69631-69646).
- g. Chronic Eustachian tube dysfunction as evidenced by retracted tympanic membrane, or recurrent otitis media, or the need for pressure-equalization (PE) tube within the last 3 years.

11. Hearing. All hearing defects are coded with ICD-9 code 389.xx.

- a. Audiometric hearing levels are measured by audiometers calibrated to the standards in American National Standards Institute [(ANSI S3.6-2004) (Reference (i))] and shall be used to test the hearing of all applicants.
- b. Current hearing threshold level in either ear greater than that described below does not meet the standard:
  - (1) Pure tone at 500, 1000, and 2000 cycles per second for each ear of not more than 30 decibels (dB) on the average with no individual level greater than 35 dB at those frequencies.
  - (2) Pure tone level not more than 45 dB at 3000 cycles per second or 55 dB at 4000 cycles per second for each ear.
  - (3) There is no standard for 6000 cycles per second.

- c. Current or history of hearing aid use (V53.2).

12. Nose, Sinuses, Mouth and Larynx.

- a. Current cleft lip or palate defects (749.xx) not satisfactorily repaired by surgery **or** that interferes with the use of wear of military equipment, or that prevents drinking from a straw.
- b. Current ulceration of oral mucosa, including tongue (528.6), excluding aphthous ulcers.
- c. Current chronic conditions of larynx including vocal cord paralysis (478.3x) or history of laryngeal papillomatosis.
- d. History of non-benign polyps (478.4) chronic hoarseness (78.49), chronic laryngitis (476.0) or spasmodic dysphonia.
- e. Current anosmia or parosmia (781.1).
- f. History of recurrent epistaxis with more than one episode per week of bright red blood from the nose occurring over a three (3) month period (784.7) within the last 3 years.
- g. Current nasal polyp or history of nasal polyps (471.x), unless more than twelve (12) months have elapsed since nasal polypectomy (CPT 30110, 30115, 31237-31240) and/or sinus surgery, and asymptomatic.
- h. Current perforation of nasal septum (478.1, 478.19, 748.1).
- i. Current chronic sinusitis (473) as evidenced by chronic purulent discharge, symptoms requiring frequent medical attention, or computed tomography (CT) scan.
- j. Current or history of deformities, or conditions or anomalies of upper alimentary tract (750.9), mouth (750.26), tongue (750.1x), palate, throat, pharynx, larynx (748.3), and nose (748.1) that interfere with chewing (V41.6), swallowing, speech, or breathing.

13. Dental.

- a. Current diseases or pathology of the jaws or associated tissues that prevent normal functioning. Those diseases or conditions include but are not limited to temporomandibular disorders (524.6x) and/or myofascial pain (784.0). A minimum of six (6) months healing time must elapse for any individual completing surgical treatment of any maxillofacial pathology lesions.

- b. Current severe malocclusion (524.00-524.29, 524.4), which interferes with normal chewing or requires immediate or protracted treatment, or a relationship between the mandible and maxilla that prevents satisfactory future prosthodontic replacement.
- c. Eight (8) or more grossly (visually) cavitated and/or carious teeth (521.0x). Applicants who are edentulous must have functioning dentures. Lack of a serviceable prosthesis that prevents adequate biting and chewing of a normal diet. Individuals undergoing endodontic care are acceptable for entry in the Delayed Entry Program (DEP) only if a civilian or military dentist or endodontist provides documentation that active endodontic treatment shall be completed prior to being sworn into active duty.
- d. Current orthodontic appliances (mounted or removable, i.e., Invisalign) for continued active treatment (V53.4). Permanent or removable retainers are permissible. Individuals undergoing active orthodontic care are acceptable for accession (including DEP) only if a civilian or military orthodontist provides documentation that active orthodontic treatment shall be completed prior to being sworn into active duty. Entrance into active duty will not occur until all orthodontic treatment is documented to be completed.

#### 14. Neck.

- a. Current symptomatic cervical ribs (756.2).
- b. Current congenital cyst(s) (744.4x) of branchial cleft origin or those developing from the remnants of the thyroglossal duct (759.2).
- c. Current contraction (723.5, 754.1) of the muscles of the neck, spastic or non-spastic, or cicatricial contracture of the neck to the extent it interferes with the proper wearing of a uniform or military equipment, or is so disfiguring as to interfere with or prevent satisfactory performance of military duty.

#### 15. Lungs, Chest Wall, Pleura, and Mediastinum.

- a. Current abnormal elevation of the diaphragm (either side) (756.6). Any nonspecific abnormal findings on radiological and other examination of body structure, such as lung field (793.1) or other thoracic or abdominal organ (793.2).
- b. Current abscess of the lung (513.0) or mediastinum (513.1).
- c. Current or history of recurrent acute infectious processes of the lung, including but not limited to viral pneumonia (480.x), pneumococcal pneumonia (481), bacterial pneumonia (482.xx), pneumonia due to other specified organism (483.x), pneumonia infectious disease classified elsewhere (484.x),

bronchopneumonia (organism unspecified) (485), pneumonia (organism unspecified) (486).

- d. Airway hyper responsiveness including asthma (493.xx), reactive airway disease, exercise-induced bronchospasm (519.11) or asthmatic bronchitis (493.90), reliably diagnosed and symptomatic after the 13th birthday.
  - (1) Reliable diagnostic criteria may include any of the following elements:  
Substantiated history of cough, wheeze, chest tightness and/or dyspnea which persists or recurs over a prolonged period of time, generally more than twelve (12) months.
  - (2) Individuals DO MEET the standard if within the past three (3) years they meet ALL of the below criteria:
    - (a) No use of controller or rescue medications (including but not limited to inhaled corticosteroids, leukotriene receptor antagonists, or short acting beta agonists).
    - (b) No exacerbations requiring acute medical treatment.
    - (c) No use of oral steroids.
    - (d) A current normal spirometry (within the past 90 days), performed in accordance with the American Thoracic Society (ATS) guidelines and as defined by current National Heart, Lung, and Blood Institute (NHLBI) standards.
- e. Chronic obstructive pulmonary disease (491).
  - (1) Current or history of bullous or generalized pulmonary emphysema (492).
  - (2) Current bronchitis (490), acute or chronic symptoms over three (3) months occurring at least twice a year.
- f. Current or history of bronchiectasis (494). Bronchiectasis during the first year of life is not disqualifying if there are no residual or sequelae.
- g. Current or history of bronchopleural fistula (510), unless resolved with no sequelae.
- h. Current chest wall malformation (754.89), including but not limited to pectus excavatum (754.81) or pectus carinatum (754.82), if these conditions interfere with vigorous physical exertion.
- i. History of empyema (510.9).

- j. Pulmonary fibrosis (515).
- k. Current foreign body in lung (934.8, 934.9), trachea (934.0), or bronchus (934.1).
- l. History of thoracic surgery (32-33), (CPT 32035-32999, 33010-33999, 43020-43499) including open and endoscopic procedures.
- m. Current or history of pleurisy with effusion (511.9) within the previous two (2) years.
- n. Current or history of pneumothorax (512) occurring during the year preceding examination if due to trauma (860) or surgery, or occurring during the two (2) years preceding examination from spontaneous (512.8) origin.
- o. Recurrent spontaneous pneumothorax (512.8).
- p. History of chest wall surgery (34-34.9), including breast (85-85.9), during the preceding six (6) months, or with persistent functional limitations.

16. Heart.

- a. History of valvular repair or replacement (CPT 33400-33478).
  - (1) Current or history of the following valvular conditions as defined by the current American College of Cardiology and American Heart Association guidelines:
    - (a) Severe pulmonic regurgitation.
    - (b) Severe tricuspid regurgitation.
    - (c) Moderate pulmonic regurgitation unless documented mean pulmonary artery pressure less than 25mm Hg.
    - (d) Moderate tricuspid regurgitation unless documented mean pulmonary artery pressure less than 25mm Hg.
    - (e) Moderate or severe mitral regurgitation.
    - (f) Mild, moderate or severe aortic regurgitation.
  - (2) The following are considered normal variants that meet the standards:
    - (a) Trace or mild pulmonic regurgitation.
    - (b) Trace or mild tricuspid regurgitation.



- (c) Trace or mild mitral regurgitation in the absence of mitral valve prolapse.
  - (d) Trace Aortic insufficiency.
- b. Mitral valve prolapsed (396.3) with normal exercise tolerance not requiring medical therapy DOES meet the standard.
- c. Bicuspid aortic valve (746.4), in the absence of stenosis or regurgitation as in 16.a.(1) above, DOES meet the standard.
- d. All valvular stenosis (396).
- e. Current or history of atherosclerotic coronary artery disease (410).
- f. Current history of pacemaker or defibrillator implantation (CPT 3320-33249).
- g. History of supraventricular tachycardia (427.0).
  - (1) History of recurrent or atrial fibrillation (427.31) or flutter (427.32).
  - (2) Supraventricular tachycardia (427.0) associated with an identifiable reversible cause and no recurrence during the preceding two (2) years while off all medications DOES meet the standard.
  - (3) Those with identified atrioventricular nodal reentrant tachycardia or atrioventricular reentrant tachycardia [(such as Wolff-Parkinson-White (WPW) syndrome (426.7)] who have undergone successful ablative therapy with no recurrence of symptoms after three (3) months and with documentation of normal electrocardiograph (ECG) meet the standard.
- h. Premature atrial or ventricular contractions sufficiently symptomatic to require treatment, or result in physical or physiological impairment.
- i. Abnormal ECG patterns (794.31):
  - (1) Long QT (426.82).
  - (2) Brugada pattern.
  - (3) WPW syndrome (426.7) pattern unless associated with low risk accessory pathway by appropriate diagnostic testing.
- j. Current or history of ventricular arrhythmias (427.1) including ventricular fibrillation, tachycardia, or multifocal premature

ventricular contractions. Occasional asymptomatic unifocal premature ventricular contractions meet the standard.

- k. Current or history of conduction disorders, including but not limited to disorders of sinus arrest, asystole, Mobitz type II second-degree atrioventricular (AV) block (426.12), and third-degree AV block (426.0).
- l. In the absence of cardiovascular symptoms the following meet the standard:
  - (1) Sinus arrhythmia.
  - (2) First degree AV block (426.11).
  - (3) Left axis deviation of less than -45 degrees.
  - (4) Early repolarization.
  - (5) Incomplete right bundle branch block.
  - (6) Wandering atrial pacemaker (427.89) or ectopic atrial rhythm (427.89).
  - (7) Sinus bradycardia (427.81).
  - (8) Mobitz type I second-degree AV block (426.13)
- m. Current or history of conduction disturbances such as left anterior hemiblock (426.2), right or left bundle branch block (426.4) do not meet the standard unless asymptomatic with a normal echocardiogram.
- n. Current or history of cardiomyopathy (425), cardiomegaly, hypertrophy (defined as septal wall thickness of 15mm or greater), dilation (429.3) or congestive heart failure (428).
- o. History of myocarditis (422) or pericarditis (420) unless the individual is free of all cardiac symptoms, does not require medical therapy, and has normal echocardiography for at least one year.
- p. Current persistent tachycardia (785.0) (as evidenced by average heart rate of 100 beats per minute or greater over a 24 hour period of continuous monitoring).

- q. Current or history of congenital anomalies of heart and great vessels (746). The following conditions meet the standard with an otherwise normal current (within 6 months) echocardiogram.
  - (1) Dextrocardia (746.87) with Situs inversus (759.3) without any other anomalies.
  - (2) Ligated or occluded patent ductus arteriosus (747.0).
  - (3) Corrected atrial septal defect (745.9) or patent foramen ovale (745.5) without residua.
  - (4) Corrected ventricular septal defect (745.4) without residua.
- r. History of recurrent syncope and/or presyncope (780.2), including black out, fainting, loss of alteration of level of consciousness (excludes vasovagal reactions with identified trigger such as venipuncture) unless there has been no recurrence during the preceding two (2) years while off all medications.
- s. Unexplained ongoing or recurring cardiopulmonary symptoms (to include but not limited to syncope, presyncope, chest pain, palpitations, and dyspnea on exertion) that impairs a physically active lifestyle.
- t. History of rheumatic fever (390).

17. Abdominal Organs and Gastrointestinal System.

- a. Esophageal Disease.
  - (1) Current or history of esophageal disease (530.0-530.9), including but not limited to ulceration, varices, fistula, achalasia.
  - (2) Gastro-Esophageal Reflux Disease (GERD) (530.81), with complications.
    - (a) Stricture or B-ring.
    - (b) Dysphagia.
    - (c) Recurrent symptoms or esophagitis despite maintenance medication.
    - (d) Barrett's esophagitis
    - (e) Extraesophageal complications; reactive airway disease; recurrent sinusitis or dental complications.
  - (3) History of surgical correction (fundoplication or dilation) for GERD within six (6) months (45.89).
  - (4) Current or history of dysmotility disorders to include diffuse esophageal spasm, nutcracker esophagus, non-specific motility disorder, and achalasia.

- (5) Eosinophilic esophagitis.
- (6) Other esophageal strictures, for example lye other caustic ingestion.
- b. Stomach and Duodenum.
  - (1) Current dyspepsia requiring medication; or history of dyspepsia lasting three (3) or more consecutive months and requiring medication within the preceding twelve (12) months.
  - (2) Gastric or duodenal ulcers:
    - (a) Current ulcer or history of treated ulcer within the last three (3) months.
    - (b) Recurrent or complicated by bleeding, obstruction, or perforation within the preceding five (5) years confirmed by endoscopy.
  - (3) History of surgery for peptic ulceration or perforation (533.0-599.9).
  - (4) History of gastroparesis.
  - (5) History of bariatric surgery of any type (e.g., lap-band or gastric bypass surgery for weight loss).
  - (6) History of gastric varices.
- c. Small and Large Intestine.
  - (1) Current or history of inflammatory bowel disease, including but not limited to undetermined (558.9), Crohn's disease (555), ulcerative colitis (556), or ulcerative proctitis (556.2).
  - (2) Current infectious colitis not otherwise specified (009.1).
  - (3) Current or history of intestinal malabsorption syndromes (579.9), including but not limited to celiac sprue, pancreatic insufficiency, post-surgical and idiopathic (579). Lactase deficiency does not meet the standard only if of sufficient severity to require frequent intervention, or to interfere with normal function.
  - (4) Current or history of gastrointestinal functional and motility disorders within the past two (2) years, including but not limited to pseudo-obstruction, megacolon, history of volvulus, or chronic constipation (564.0) and or diarrhea (787.91), regardless of cause, persisting or symptomatic in the past two (2) years.
  - (5) History of gastrointestinal bleeding (578), including positive occult blood (792.1), if the cause has not been corrected. Meckel's diverticulum (751.0),

if surgically corrected more than six (6) months prior DOES meet the standard.

- (6) Current history of irritable bowel syndrome (564.1) of sufficient severity to require frequent intervention or prescription medication or to interfere with normal function.
- (7) History of bowel resection (CPT 44202-44203).
- (8) Current or history of symptomatic diverticular disease of the intestine (562).
- (9) Personal or family history of familial adenomatous polyposis syndrome or hereditary non-polyposis colon cancer syndrome.

d. Hepatic-Biliary Tract.

- (1) Current acute or chronic hepatitis, hepatitis carrier state (070), hepatitis in the preceding six (6) months or persistence of symptoms after six (6) months, or objective evidence of impairment of liver function.
- (2) Current or history of cirrhosis (571), hepatic cysts (573.8), abscess (572.0), or sequelae of chronic liver disease (571.3).
- (3) Current or history of symptomatic cholecystitis (575.10), unless successfully surgically corrected; postcholecystectomy syndrome; or other disorders of the gallbladder and biliary system (576). Cholecystectomy DOES meet the standard if performed greater than six (6) months prior to examination and patient remains asymptomatic. Endoscopic procedure to correct choledocholithiasis, if performed greater than six (6) months prior to examination and patient remains asymptomatic, MAY meet the standard.
- (4) History of sphincter of Oddi dysfunction.
- (5) Choledochocyst.
- (6) Primary biliary cirrhosis or primary sclerosing cholangitis.
- (7) Current or history of pancreatitis, acute (577.0) or chronic (577.1).
- (8) Pancreatic cyst.
- (9) History of pancreatic surgery.
- (10) Current or history of metabolic liver disease, including but not limited to hemochromatosis (275.0), Wilson's disease (275.1), or alpha-1 anti-trypsin deficiency (273.4). Gilbert's syndrome DOES meet the standard.

(11) Current enlargement of the liver from any cause (789.1).

e. Anorectal.

(1) Current anal fissure or anal fistula (565).

(2) Current or history of anal or rectal polyp (569.0), prolapse (569.1), stricture (569.2), or fecal incontinence (787.6) within the last two (2) years. History of removal of juvenile or inflammatory polyp DOES meet the standard.

(3) Current hemorrhoid (internal or external), when large, symptomatic, or with a history of bleeding (455) within the last sixty (60) days.

f. Abdominal Wall.

(1) Current hernia (except for small or asymptomatic umbilical hernias), including but not limited to uncorrected inguinal (550) and other abdominal wall hernias (553).

(2) History of open or laparoscopic abdominal surgery (CPT 22900-22999, 43500-49999) during the preceding six (6) months (P54). Uncomplicated laparoscopic appendectomies (CPT 44970) meet the standard after three (3) months.

g. Obesity.

(1) History of any gastrointestinal procedure for the control of obesity is (CPT 43644-43645, 43770-43775, 43842-43848, 43886-43888 or artificial openings, including but not limited to ostomy (V44).

18. Female Genitalia.

a. Current or history of abnormal menstruation unresponsive to medical management within the last twelve (12) months, including but not limited to menorrhagia, metrorrhagia, or polymenorrhea.

b. Primary amenorrhea (626.0).

c. Current unexplained secondary amenorrhea (626.0).

d. Current dysmenorrhea (625.3) that is unresponsive to medical therapy and is incapacitating to a degree recurrently requiring absences of more than a few hours from routine activities.

e. Endometriosis (617) that is unresponsive to medical therapy.

- f. History of major abnormalities or defects of the genitalia including but not limited to change of sex (P64.5) (CPT 55970, 55980), hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis (752.7).
- g. Persistent or clinically significant ovarian cyst(s) (620.2).
- h. Polycystic ovarian syndrome (256.4) with metabolic complications.
- i. Pelvic inflammatory disease (614) within the preceding thirty (30) days.
- j. Chronic pelvic pain or unspecified symptoms associated with female genital organs (625.9).
- k. Pregnancy (V22) through six (6) months after the completion of the pregnancy (CPT 59150, 59151, 59400, 59409, 59510, 59514, 59610, 59612, 59812-59857).
- l. Symptomatic uterine enlargement due to any cause (621.2).
- m. Current history of genital infection or ulceration, including but not limited to, herpes genitalis (054.11) or condyloma acuminatum (078.11), if of sufficient severity to require frequent intervention or to interfere with normal function. Herpes does not meet the standard if:
  - (1) Current lesions are present.
  - (2) Chronic suppressive therapy is needed.
  - (3) There are three (3) or more outbreaks per year.
  - (4) Any outbreaks in the past twelve (12) months interfered with normal function.
  - (5) Treatment included hospitalization or intravenous therapy.
- n. Abnormal gynecologic cytology within the preceding two (2) years, including but not limited to, unspecified abnormalities of the Papanicolaou smear of the cervix (795.0), excluding atypical squamous cells of undetermined significance without Human Papilloma Virus (079.4) and confirmed low-grade squamous intraepithelial lesion (622.9). For the purposes of this Instruction, confirmation is by colposcopy or repeat cytology.

19. Male Genitalia.

- a. Absence of one or both testicles, congenital (752.89) or undescended (752.51).
- b. Current or history of epispadias (752.62).



- c. Current or history of surgery for proximal hypospadias (752.61).
- d. Distal (coronal) hypospadias without history of surgery DOES meet the standard.
- e. Distal (coronal) hypospadias treated with surgery when accompanied by evidence of urinary tract infection, urethral stricture, or voiding dysfunction.
- f. Current enlargement or mass of testicle, epididymis (608.9) or spermatic cord.
- g. Current or history of recurrent orchitis or epididymitis (604.90).
- h. History of penis amputation (878.0) (CPT 54125, 54130-54135).
- i. Current penile curvature if associated with pain.
- j. Current or history of genital infection or ulceration, including but not limited to herpes genitalis (054.13) or condyloma acuminatum (078.11), if of sufficient severity to require frequent intervention or to interfere with normal function. Herpes does not meet the standard if:
  - (1) Current lesions are present.
  - (2) Use of chronic suppressive therapy is needed.
  - (3) There are three or more outbreaks per year.
  - (4) Any outbreaks in the past twelve (12) months interfered with normal function.
  - (5) Treatment included hospitalization or intravenous therapy.
- k. Current or history of urethral condyloma acuminatum.
- l. Current acute prostatitis (601.0), chronic prostatitis (601.1), or chronic pelvic pain syndrome .
- m. Current hydrocele (603) or spermatocele associated with pain or which precludes a complete exam of the scrotal contents.
- n. Left varicocele (456.4), if painful or symptomatic, or associated with testicular atrophy, or varicocele larger than the testis.
- o. Left varicocele (456.4) that does not reduce or decompress completely when supine.
- p. Bilateral or right varicocele (456.4).

- q. Current or history of chronic or recurrent scrotal pain or unspecified symptoms associated with male genital organs (608.9).
- r. History of major abnormalities or defects of the genitalia such as change of sex (P64.5) (CPT 55970, 55980), hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis (752.7).

20. Urinary System.

- a. Current or history of chronic recurrent cystitis (595), interstitial cystitis, or painful bladder syndrome.
- b. Current urethritis, or history of chronic or recurrent urethritis (597.80).
- c. History or treatment of the following voiding symptoms within the previous twelve (12) months:
  - (1) Urinary frequency or urgency more than every two (2) hours on a daily basis.
  - (2) Nocturia more than two (2) episodes during sleep period.
  - (3) Enuresis (788.30).
  - (4) Incontinence of urine, such as urge or stress.
  - (5) Urinary retention.
  - (6) Dysuria.
- d. History of need for urinary catheterization with intermittent or indwelling catheter for any period greater than two (2) weeks.
- e. History of bladder augmentation, urinary diversion, or urinary tract reconstruction.
- f. Current or history of abnormal urinary findings:
  - (1) Gross hematuria (599.7).
  - (2) Microscopic hematuria (3 or more red blood cells per high-powered field on 2 of 3 properly collect urinalysis).
  - (3) Pyuria (6 or more white blood cells per high-powered field in 2 or 3 properly collected urinalysis).
- g. Current or recurrent urethral or ureteral stricture (598) or fistula (599.1) involving the urinary tract.

- h. Conditions associated with the kidneys, including:
  - (1) Current absence of one kidney, congenital (753.0) or acquired (V45.73) (CPT 50220-50236).
  - (2) Asymmetry in size or function of kidneys.
  - (3) History of renal transplant.
  - (4) Current chronic or recurrent pyelonephritis (590.0) or any other unspecified infections of the kidney (590.9)
  - (5) Current or history of polycystic kidney (753.1).
  - (6) Current or history of horseshoe kidney (753.3).
  - (7) Current or history of hydronephrosis (591).
  - (8) Current or history of acute (580) nephritis or chronic (582) kidney disease of any type.
  - (9) History of acute kidney injury requiring dialysis.
  - (10) Current or history of proteinuria (791.0) with a protein-to-creatinine ratio greater than 0.2 in a random urine sample more than 48 hours after strenuous activity. Benign orthostatic proteinuria MEETS the standard.
  - (11) Current or history of symptomatic urolithiasis (592) within the preceeding 12 months.
  - (12) History of stone(s) greater than 4mm in size, recurrent calculus, nephrocalcinosis, or bilateral renal calculi at any time.
  - (13) History of urolithiasis requiring surgical treatment or intervention requiring hospitalization.

21. Spine and Sacroiliac Joints.

- a. Ankylosing spondylitis or other inflammatory spondylopathies (720).
- b. Current or history of any condition, including but not limited to the spine or sacroiliac joints, with or without objective signs, if:
  - (1) It prevents the individual from successfully following a physically active vocation in civilian life (724), or is associated with local or referred pain to the extremities, muscular spasms, postural deformities, or limitation in motion.
  - (2) It requires external support.

- (3) It requires limitation of physical activity or frequent treatment.
- c. Current deviation or curvature of spine (737) from normal alignment, structure, or function if:
  - (1) It prevents the individual from following a physically active vocation in civilian life.
  - (2) It interferes with the proper wearing of a uniform or military equipment.
  - (3) It is symptomatic.
  - (4) There is lumbar or thoracic scoliosis greater than 30 degrees, or kyphosis and lordosis greater than 50 degrees when measured by the Cobb Method.
- d. History of congenital fusion (756.15) involving more than two vertebral bodies or any surgical fusion of spinal vertebrae (P81.0).
- e. Current or history of fracture or dislocation of the vertebra (805).
  - (1) Vertebral fractures that do not meet the standards:
    - (a) Compression fractures involving more than or equal to 25 percent of a single vertebra.
    - (b) Compression fractures involving less than 25 percent of a single vertebra occurring within the past twelve (12) months or it is symptomatic.
    - (c) Any compression fracture that is symptomatic.
  - (2) Vertebral fractures that meet the standard:
    - (a) Compression fractures involving less than 25 percent of a single vertebra if it occurred more than one (1) year before the accession exam and the applicant is asymptomatic,
    - (b) A history of fractures of the transverse or spinous process IF the applicant is asymptomatic.
- f. History of juvenile epiphysitis (732.6) with any degree of residual change indicated by X-ray or kyphosis.
- g. Current herniated nucleus pulposus (722) or history of surgery to correct (CPT 63001-63200). A surgically corrected asymptomatic single-level lumbar or thoracic disectomy with full resumption of unrestricted activity DOES meet the standard.

- h. Current or history of spina bifida (741) when symptomatic, when there is more than one vertebral level involved or with dimpling of the overlying skin. History of surgical repair of spina bifida.
- i. Current or history of spondylolysis congenital (756.10-756.12), or acquired (738.4).
- j. Current or history of spondylolisthesis congenital (756.12) or acquired (738.4).

## 22. Upper Extremities.

- a. Limitation of motion. Current active joint ranges of motion less than:
  - (1) Shoulder (726.1)
    - (a) Forward elevation to 90 degrees.
    - (b) Abduction to 90 degrees.
  - (2) Elbow (726.3)
    - (a) Flexion to 130 degrees.
    - (b) Extension to 15 degrees.
  - (3) Wrist (726.4).
    - (a) Total range of 60 degrees (extension plus flexion), or radial and ulnar deviation combined arc 30 degrees.
  - (4) Hand (726.4)
    - (a) Pronation to 45 degrees.
    - (b) Supination to 45 degrees.
  - (5) Fingers and Thumb (726.4). Inability to clench fist, pick up a pin, grasp an object, or touch tips of at least three fingers with thumb.
- b. Hand and Fingers
  - (1) Absence of the distal phalanx of either thumb (885).
  - (2) Absence of any portion of the index finger.
  - (3) Absence of distal and middle phalanx of the middle, or ring finger of either hand irrespective of the absence of little finger (886).

- (4) Absence of more than the distal phalanx of any two of the following: index, middle, or ring finger of either hand (886).
  - (5) Absence of hand or any portion thereof (887), except for specific absence of fingers as noted above.
  - (6) Current polydactyly (755.0).
  - (7) Intrinsic paralysis or weakness of upper limbs, including but not limited to nerve paralysis, carpal tunnel and cubital syndromes, lesion of ulnar, median, or radial nerve (354), sufficient to produce physical findings in the hand such as muscle atrophy and weakness.
- c. Residual Weakness and Pain. Current disease, injury, or congenital condition with residual weakness or symptoms that prevents satisfactory performance of duty, including but not limited to chronic joint pain associated with the shoulder (719.41), the upper arm (719.42), the forearm (719.43), and the hand (719.44); or chronic joint pain as a late effect of fracture of the upper extremities (905.2), as a late effect of sprains without mention of injury (905.7), and as late effects of tendon injury (905.8).

23. Lower Extremities.

- a. General
- (1) Current deformities, or chronic joint pain of pelvic region, thigh (719.45), lower leg (719.46), knee (717.9), ankle and or foot (719.47), that have interfered with function to such a degree as to prevent the individual from following a physically active vocation in civilian life, or that would interfere with walking, running, weight bearing, or the satisfactory completion of military training.
  - (2) Current leg-length discrepancy resulting in a limp (736.81).
- b. Limitation of Motion. Current active joint ranges of motion less than:
- (1) Hip (due to disease (726.5) or injury (905.2)).
    - (a) Flexion to 90 degrees.
    - (b) No demonstrable flexion contracture.
    - (c) Extension to 10 degrees (beyond 0 degrees).
    - (d) Abduction to 45 degrees.
    - (e) Rotation of 60 degrees (internal and external combined).
  - (2) Knee (due to disease (726.6) or injury (905.4)).

- (a) Full extension to 0 degrees.
- (b) Flexion to 110 degrees.
- (3) Ankle (due to disease (726.7) or injury (905.4) or congenital).
  - (a) Dorsiflexion to 10 degrees.
  - (b) Planter flexion to 30 degrees.
  - (c) Subtalar eversion and inversion totaling 5 degrees.
- c. Foot and Ankle.
  - (1) Current absence of a foot or any portion thereof (896).
  - (2) Absence of a single lesser toe or any portion thereof that is symptomatic and does not impair function meets the standard.
  - (3) Deformity of the toes (735.9) that prevents the proper wearing of military footwear or impairs walking, marching, running, maintaining balance or jumping.
  - (4) Symptomatic deformity of the toes (acquired (735) or congenital (755.66)), including but not limited to conditions such as hallux valgus (735.0), hallux varus (735.1), hallux rigidus (735.2), hammer toe(s) (735.4), claw toe(s) (735.5), or overriding toe(s) (735.8).
  - (5) Clubfoot (754.70) or pes cavus (754.71) that prevents the proper wearing of military footwear or causes symptoms when walking, marching, running, or jumping.
  - (6) Rigid or symptomatic pes planus (acquired (734), congenital (754.61)).
  - (7) Current ingrown toenails (703.0), if infected or symptomatic.
  - (8) Current or history of recurrent plantar fasciitis (728.71).
  - (9) Symptomatic neuroma (355.6).
- d. Leg, Knee, Thigh, and Hip.
  - (1) Current loose or foreign body in the knee joint (717.6).
  - (2) History of uncorrected anterior (717.83) or posterior (717.84) cruciate ligament injury.
  - (3) History of surgical reconstruction of knee ligaments (P81.4) (CPT 27427-27429) DOES meet the standard if twelve (12) months has elapsed since reconstruction, and the knee is asymptomatic and stable.



- (4) Recurrent ACL reconstruction (CPT 27427-27407).
- (5) Symptomatic medial (717.82) or lateral (717.42) meniscal injury. The following DOES meet the standard if asymptomatic and released to full and unrestricted activity:
  - (a) Meniscal repair (CPT 27403), at greater than six (6) months after surgery.
  - (b) Partial meniscectomy (CPT 27332-27333) more than three (3) months after surgery.
- (6) Meniscal transplant (CPT 29868).
- (7) Symptomatic medial (844.1) and lateral (844.0) collateral ligament instability.
- (8) Current or history of congenital dislocation of the hip (754.3), osteochondritis of the hip (Legg-Perthes Disease) (732.1), or slipped capital femoral epiphysis of the hip (732.2).
- (9) Hip dislocation (835) within two (2) years preceding examination. Hip dislocation after two (2) years meets the standard if asymptomatic and released to full unrestricted activity.
- (10) Symptomatic osteochondritis of the tibial tuberosity (Osgood- Schlatter Disease) (732.4) within the past twelve (12) months.
- (11) Stress fractures (733.95, V13.52), recurrent or single episode during the past twelve (12) months.

24. Miscellaneous Conditions of the Extremities.

- a. Current or history of chondromalacia (717.7), including but not limited to chronic patello-femoral pain syndrome and retro-patellar pain syndrome (719.46), osteoarthritis (715.3), or traumatic arthritis (716.1).
- b. Current joint dislocation if unreduced, or history of recurrent dislocations, subluxations or instability of the hip (835), elbow (832), ankle (837).
- c. History of any dislocation, subluxations or instability of the knee (718.86) or shoulder.
- d. Current or history of osteoarthritis (715.3) or traumatic arthritis (716.1) of isolated joints that has interfered with a physically active lifestyle, or that prevents the satisfactory performance of military duty.
- e. Fractures.

- (1) Current malunion or non-union of any fracture (733.8) (except asymptomatic ulnar styloid process fracture).
  - (2) Current retained hardware (including plates, pins, rods, wires, or screws) used for fixation that is symptomatic or interferes with proper wearing of protective equipment or military uniform. Retained hardware is not disqualifying if fractures are healed, ligaments are stable, and there is no pain.
- f. Current orthopedic implants or devices to correct congenital or post-traumatic orthopedic abnormalities (V43).
  - g. Current or history of contusion of bone or joint (923, 924); an injury of more than a minor nature which shall interfere or prevent performance of military duty, or shall require frequent or prolonged treatment, without fracture, nerve injury, open wound, crush or dislocation, which occurred in the preceding six (6) months and recovery has not been sufficiently completed or rehabilitation resolved.
  - h. History of joint replacement of any site (V43.6) (CPT 24363, 27130-27132, 27447)).
  - i. Current or history of neuromuscular paralysis, weakness, contracture, or atrophy (728), of sufficient degree to interfere with or prevent satisfactory performance of military duty, or requires frequent or prolonged treatment.
  - j. Current symptomatic osteochondroma or history of multiple osteocartilaginous exostoses (727.82).
  - k. Current osteoporosis (733.0) as demonstrated by a reliable test such as a dual energy x-ray absorptiometry (DEXA) scan.
  - l. Current osteopenia (733.9) until resolved.
  - m. Current osteomyelitis (730.0) or history of recurrent osteomyelitis.
  - n. Current or history of osteochondral defect, formerly known as osteochondritis dissecans (732.7).
  - o. History of cartilage surgery to include but not limited to cartilage debridement, chondroplasty, microfracture, or cartilage transplant procedure (CPT 20910, 20912, 21230, 21235, 27412, 27415, 29866-29867).
  - p. Current or history of any post-traumatic (958.9) or exercise induced (729.7-79) compartment syndrome.
  - q. Current or history of avascular necrosis of any bone.

- r. Current or history of recurrent tendon disorder including but not limited to tendonitis, tendonopathy, or tenosynovitis.

25. Vascular System.

- a. Current or history of abnormalities of the arteries (447), including but not limited to aneurysms (442), arteriovenous malformations, atherosclerosis (440), or arteritis (such as Kawasaki's disease) (446).
- b. Current or medically managed hypertension (401). Hypertension is defined as systolic pressure greater than 140 mmHg and/or diastolic pressure greater than 90 mmHg confirmed by manual blood pressure (BP) cuff averaged over two or more properly measured, seated, blood pressure readings on each of two or more consecutive days (isolated, single day BP elevation is not disqualifying unless confirmed on two or more consecutive days).
- c. Current or history of peripheral vascular disease (443.9), including but not limited to diseases such as Raynaud's Disease (443.0), and vasculidities.
- d. Current or history of venous diseases, including but not limited to recurrent thrombophlebitis (451), thrombophlebitis during the preceding year, or evidence of venous incompetence, such as large or symptomatic varicose veins, edema, or skin ulceration (454).
- e. Current or history of deep venous thrombosis (453.40).
- f. History of operation or endovascular procedure on the arterial or venous systems, including but not limited to vena cava filter, angioplasty, venoplasty, thrombolysis, or stent placement (CPT 34001-37799).
- g. History of Marfan's Syndrome (759.82).

26. Skin and Cellular Tissues.

- a. Current diseases of sebaceous glands including severe and/or cystic acne (706), or hidradenitis suppurativa (704-705), if extensive involvement of the neck, scalp, axilla, groin, shoulders, chest, or back is present or shall be aggravated by or interfere with the proper wearing of military equipment. Applicants under treatment with systemic retinoids, including but not limited to isotretinoin (Accutane ®), do not meet the standard until eight (8) weeks after completion of therapy.
- b. Current or history of atopic dermatitis (691) or eczema (692.9) after the twelfth (12<sup>th</sup>) birthday.
  - (1) Atopic Dermatitis. Active or history of residual or recurrent lesions in characteristic areas (face, neck, antecubital and/or popliteal fossae, occasionally wrists and hands).

- (2) Non-Specific Dermatitis. Current or history of recurrent or chronic non-specific dermatitis to include contact (692) (irritant or allergic), or dyshidrotic dermatitis (705.81) requiring more treatment than with over the counter medications.
- c. Cysts if:
  - (1) The current cyst (706.2) (other than pilonidal cyst) is of such a size or location as to interfere with the proper wearing of military equipment.
  - (2) The current pilonidal cyst (685) is evidenced by the presence of a tumor mass or a discharging sinus, or is a surgically resected pilonidal cyst (CPT 11770-11772) that is symptomatic, unhealed, or less than six (6) months post-operative.
- d. Current or history of bullous dermatoses (694), including but not limited to dermatitis herpetiformis, pemphigus, and epidermolysis bullosa (757.39). Resolved bullous impetigo does meet the standards.
- e. Current or chronic lymphedema (457.1).
- f. Current or history of furunculosis or carbuncle (680) if extensive, recurrent, or chronic.
- g. Current or history of severe hyperhidrosis of hands or feet (705.2, 780.8), unless controlled by topical medications.
- h. Current or history of congenital (757) or acquired (216) anomalies of the skin, such as nevi or vascular tumors that interfere with function, or are exposed to constant irritation. History of Dysplastic Nevus Syndrome (232).
- i. Current or history of keloid formation (701.4), including pseudofolliculitis and keloidalis nuchae (706.1), if that tendency is marked or interferes with the proper wearing of military equipment.
- j. Current lichen planus (cutaneous and/or oral) (697.0).
- k. Current or history of neurofibromatosis (Von Recklinghausen's Disease) (237.7).
- l. History of photosensitivity (692.72), including but not limited to any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria, or any dermatosis aggravated by sunlight, such as lupus erythematosus.
- m. Current or history of psoriasis (696.1).
- n. Current or history of radiodermatitis (692.82).

- o. Current or history of scleroderma (710.1).
- p. Current or history of chronic urticaria lasting longer than six (6) weeks or recurrent episodes of urticaria (708.8) within the past two (2) years not associated with angioedema, hereditary angioedema (277.6) or maintenance therapy for chronic urticaria, even if not symptomatic.
- q. Current symptomatic plantar wart(s) (078.19).
- r. Current scars (709.2), or any other chronic skin disorder of a degree or nature that requires frequent outpatient treatment or hospitalization, which in the opinion of the certifying authority shall interfere with proper wearing of military clothing or equipment, or which exhibits a tendency to ulcerate or interferes with the satisfactory performance of duty.
- s. Prior burn (949) injury involving 18 percent or more of the body surface area (including graft sites), or resulting in functional impairment to such a degree, due to scarring, as to interfere with the satisfactory performance of military duty due to decreased range of motion, strength, or agility.
- t. Current localized types of fungus infections (117), interfering with the proper wearing of military equipment or the performance of military duties. For systemic fungal infections, refer to paragraph 28.v.

27. Blood and Blood-Forming Tissues.

- a. Current hereditary or acquired anemia, which has not been corrected with therapy before appointment or induction. ICD-9 codes for diagnosed anemia include hereditary hemolytic anemia (282), sickle cell disease (282.6), acquired hemolytic anemia (283), aplastic anemia (284), or unspecified anemias (285).
- b. Current or history of coagulation defects (286), including but not limited to von Willebrand's Disease (286.4), idiopathic thrombocytopenia (287), Henoch-Schönlein Purpura (287.0).
- c. Current or history of diagnosis of any form of chronic or recurrent agranulocytosis and/or leukopenia (288.0).
- d. Spleen
  - (1) Current splenomegaly (789.2).
  - (2) History of splenectomy (P41.5) (CPT 38100-38129), except when accomplished for trauma or conditions unrelated to the spleen or for hereditary spherocytosis (282.0).

28. Systemic.

- a. Current or history of disorders involving the immune mechanism, including immunodeficiencies (279).
- b. Presence of Human Immunodeficiency Virus or serologic evidence of infection (042, V08) or false positive screening test(s) with ambiguous results on confirmatory immunologic testing.
- c. Tuberculosis (010).
  - (1) Current active tuberculosis or substantiated history of active tuberculosis in any form or location, regardless of past treatment, in the previous two (2) years.
  - (2) Current residual physical or mental defects from past tuberculosis that shall prevent the satisfactory performance of duty.
  - (3) Individuals with a past history of active tuberculosis greater than two (2) years before appointment, enlistment, or induction are qualified if they have received a complete course of standard chemotherapy for tuberculosis.
  - (4) Current or history of untreated latent tuberculosis (positive Purified Protein Derivative with negative chest x-ray) (795.5). Individuals with a tuberculin reaction in accordance with American Thoracic Society (ATS) and U.S. Public Health Service (USPHS) guidelines are eligible for enlistment, induction, and appointment, provided they have received chemoprophylaxis in accordance with ATS and USPHS guidelines. A negative QuantiFERON®-TB Gold (QFT®-G) with a positive tuberculin skin test DOES meet the standard.
- d. Current untreated syphilis (097).
- e. History of anaphylaxis (995.0).
  - (1) History of anaphylaxis to stinging insects (989.5). A cutaneous only reaction to a stinging insect under the age of sixteen (16) does meet the standard. Applicants who have been treated for 3-5 years with maintenance venom immunotherapy do meet the standard.
  - (2) History of systemic allergic reaction to food or food additives (995.60-995.69). Systemic allergic reaction may be defined as a temporally related, systemic, often multi-system, reaction to a specific food. The presence of a food-specific immunoglobulin E antibody without a correlated clinical history does meet the standard.
  - (3) Oral allergy syndrome.

- (4) Hypersensitivity to latex (V15.07).
  - (5) Exercise induced anaphylaxis (with or without food).
  - (6) Idiopathic anaphylaxis (995.0).
  - (7) Acute, early, or immediate anaphylactic onset.
  - (8) History of systemic allergic reaction or angioedema.
  - f. Current residual of tropical fevers, including but not limited to fevers, such as malaria (084) and various parasitic or protozoan infestations that prevent the satisfactory performance of military duty.
  - g. History of malignant hyperthermia (995.86).
  - h. History of industrial solvent or other chemical intoxication (982) with sequelae.
  - i. History of motion sickness (994.6) resulting in recurrent incapacitating symptoms or of such a severity to require pre-medication in the previous three (3) years.
  - j. History of rheumatic fever (390).
  - k. Current or history of muscular dystrophies (359) or myopathies.
  - l. Current or history of amyloidosis (277.3).
  - m. Current or history of eosinophilic granuloma (277.8) and all other forms of the Histiocytosis (202.3). Healed eosinophilic granuloma, when occurring as a single localized bony lesion and not associated with soft tissue or other involvement does meet the standard.
  - n. Current or history of polymyositis (710.4) or dermatomyositis complex (710.3) with skin involvement.
  - o. History of rhabdomyolysis (728.88).
  - p. Current or history of sarcoidosis (135).
  - q. Current systemic fungus infections (117). For localized fungal infections, refer to Paragraph 26.s of this Section.
29. Endocrine and Metabolic.
- a. Current adrenal dysfunction (255).
  - b. Diabetes mellitus (250) disorders, including:



- (1) Current or history of diabetes mellitus (250).
- (2) Current or history of pre-diabetes mellitus defined as fasting plasma glucose 110-125 milligrams per deciliter (mg/dL) and glycosylated hemoglobin greater than 5.7 percent.
- (3) History of gestational diabetes mellitus.
- (4) Current persistent glycosuria, when associated with impaired glucose tolerance (250) or renal tubular defects (271.4).
- c. Current or history of pituitary dysfunction (253) to include history of growth hormone use. Non-functional microadenoma (less than 1 cm) does meet the standard.
- d. Current or history of diabetes insipidus.
- e. Current or history of hyperparathyroidism (252.0) or hypoparathyroidism (252.1).
- f. Thyroid Disorders:
  - (1) Current goiter (240). Symmetrical simple goiter less than two times normal size with no nodules by ultrasound and normal thyroid function DOES meet the standard.
  - (2) Thyroid nodule (241.0). A solitary thyroid nodule less than 5mm or less than 3cm with benign histology or cytology DOES meet the standard.
  - (3) Current hypothyroidism (244). Individuals with two normal thyroid stimulating hormone tests within the preceding six (6) months does meet the standard.
  - (4) Current or history of hyperthyroidism (242.9). In remission off of anti-thyroidal medication with normal thyroid function tests for a minimum of twelve (12) months and without evidence of thyroid associated ophthalmopathy DOES meet the standard.
- g. Current nutritional deficiency diseases, including but not limited to beriberi (265.0), pellagra (265.2), and scurvy (267).
- h. Current or history of Acromegaly, including but not limited to gigantism (253.0), or other disorders of pituitary function (253).
- i. Dyslipidemia with low-density lipoprotein (LDL) greater than 200mg/dL or triglycerides greater than 400mg/dL. Dyslipidemia requiring more than one medication or LDL greater than 190mg/dL on

therapy. All those on medical management must have demonstrated no medication side effect (such as myositis, myalgias, or transminitis) for a period of six (6 months).

- j. Metabolic syndrome beyond the 35<sup>th</sup> birthday. Metabolic syndrome is defined in accordance with NHLBI and the American Heart Association (2005) as any three (3) of the following:

- (1) Medically controlled hypertension or elevated blood pressure of greater than 130 mmHg systolic or greater than 85 mmHg diastolic.
- (2) Waist circumference greater than 35 inches for women and greater than 40 inches for men.
- (3) Medically controlled dyslipidemia or triglycerides greater than 150mg/dL.
- (4) Medically controlled dyslipidemia or high-density lipoprotein less than 40 mg/dL in men or less than 50 mg/dL in women.
- (5) Fasting glucose greater than 100 mg/dL.

- k. Metabolic bone disease.

- (1) Osteopenia, osteoporosis, or low bone mass with history of fragility fracture.
- (2) Paget's disease.
- (3) Osteomalacia.
- (4) Osteogenesis imperfect.

- l. Male hypogonadism.

- m. Current or history of islet-cell tumors, nesideoblastosis, or hypoglycemia.

30. Rheumatologic.

- a. Current or history of lupus erythematosus (710.0) or mixed connective tissue disease variant (710.9).
- b. Current or history of progressive systemic sclerosis (710.1), including calcinosis, Raynaud's disease or phenomenon, esophageal dysmotility, sclerodactyly, telangiectasia (CREST) variant.
- c. Current or history of Reiter's disease (099.3).

- d. Current or history of Rheumatoid arthritis (714.0).
  - e. Current or history of Sjogren's syndrome (710.2).
  - f. Current or history of vasculitis, including but not limited to polyarteritis nodosa and allied conditions (446.0), arteritis (447.6), Behcet's (136.1), and Wegener's granulomatosis (446.4). Henoch-Schonlein Purpura occurring before the age of 19 with two (2) years remission and no sequelae does meet the standard.
  - g. History of congenital fusion (756.15) involving more than two vertebral bodies or any surgical fusion of spinal vertebrae (P81.0).
  - h. Current or history of gout (274).
  - i. Current or history of inflammatory myopathy including polymyositis or dermatomyositis.
  - j. Current or history of non-inflammatory myopathy to include but not limited to metabolic myopathy such as glycogen storage disease, lipid storage, and mitochondrial myopathy.
  - k. Current or history of fibromyalgia, myofascial pain, or chronic wide-spread pain.
  - l. Current or history of chronic fatigue syndrome.
  - m. Current or history of spondyloarthritis including ankylosing spondyloarthritis, psoriatic arthritis, reactive arthritis, or spondyloarthritis associated with inflammatory bowel disease.
  - n. Current or history of joint hypermobility syndrome.
  - o. Current or history of hereditary connective tissue disorders including but not limited to Marfan's syndrome, Ehlers-Danlos syndrome, and osteogenesis imperfecta.
31. Neurologic.
- a. Current or history of cerebrovascular conditions, including but not limited to subarachnoid (430) or intracerebral (431) hemorrhage, vascular stenosis, aneurysm, stroke, transient ischemic attack or arteriovenous malformation (437).
  - b. History of congenital or acquired anomalies of the central nervous system (742) or meningocele (741.9).
  - c. Current or history of disorders of meninges, including but not limited to cysts (349.2). Asymptomatic incidental arachnoid cyst demonstrated to be stable by

neurological imaging over a six (6) month or greater time period do meet the standard.

- d. Current or history of neurodegenerative disorders, including but not limited to those disorders affecting the cerebrum (330), basal ganglia (333), cerebellum (334), spinal cord (335), or peripheral nerves (337), or muscles (728).
- e. History of headaches (784.0), including but not limited to migraines (346) and tension headaches (307.81) that:
  - (1) Are severe enough to disrupt normal activities (such as loss of time from school or work) more than twice per year in the past two (2) years.
  - (2) Require prescription medications more than twice per year within the last two (2) years.
- f. Migraine (346) or migraine variant (346.2) associated with neurological deficits other than scotoma.
- g. Cluster headaches (339.0).
- h. History of head injury (854.0) if associated with:
  - (1) Post-traumatic seizure(s) occurring more than 30 minutes after injury.
  - (2) Persistent motor, sensory, vestibular, visual, or any other focal neurological deficit.
  - (3) Persistent impairment of cognitive function.
  - (4) Persistent alteration of personality or behavior.
  - (5) Unconsciousness of 24-hours or more post-injury.
  - (6) Amnesia or disorientation of person, place, or time of 7 days duration or longer post-injury.
  - (7) Cerebral traumatic findings, including but not limited to epidural, subdural, subarachnoid, or intracerebral hematoma on neurological imaging until resolved and 12 months has elapsed since injury.
  - (8) Associated abscess (326) or meningitis (958.8).
  - (9) Cerebrospinal fluid rhinorrhea (349.81) or otorrhea (388.61) persisting more than seven (7) days.
  - (10) Penetrating brain injury to include radiographic evidence of retained foreign body or bony fragments secondary to trauma and/or operative procedure in the brain.
- i. History of moderate head injury (854.03).
  - (1) Moderate head injuries are defined as:
    - (a) Unconsciousness of more than 30 minutes but less than 24 hours, or

- (b) Amnesia, or disorientation of person, place, or time, alone or in combination, more than 24 hours but less than 7 days duration post-injury.
  - (c) Linear skull fracture.
- (2) After twelve (12) month post-injury, applicants may be qualified if neurological examination shows no residual dysfunction or complication.
- j. History of mild head injury (854.02).
  - (1) Mild head injury is defined as:
    - (a) Unconsciousness of less than 30 minutes post-injury.
    - (b) Amnesia or disorientation of person, place, or time, alone or in combination, of less than 24 hours post-injury.
  - (2) After one month post-injury, applicants may be qualified if neurological examination shows no residual dysfunction or complications.
- k. History of persistent post-concussive symptoms (310.2) that interfere with normal activities or have duration of more than one (1) month. Such symptoms include but are not limited to headache, vomiting, disorientation, spatial disequilibrium, impaired memory, poor mental concentration, shortened attention span, dizziness, or altered sleep patterns.
- l. Current or history of infectious processes of the central nervous system, including but not limited to meningitis (322), encephalitis (323), neurosyphilis (094), or brain abscess (324), if occurring within one (1) year before examination, required surgical treatment, or if there are residual neurological defects.
- m. Current or history of paralysis, lack of coordination, chronic pain (including but not limited to chronic regional pain or neuralgias), or sensory disturbance or other specified paralytic syndromes (344), including but not limited to Guillain-Barre Syndrome (357.0).
- n. Any seizure occurring beyond the 6<sup>th</sup> birthday, unless the applicant has been free of seizures for a period of five (5) years while taking no medication for seizure control, and has a normal sleep-deprived electroencephalogram and normal neurology evaluation while taking no medications for seizure control.
- o. Chronic nervous system disorders, including but not limited to myasthenia gravis (358.0), multiple sclerosis (340), tremor (333.1), and tic disorder (307.20) [(e.g. Tourette's (307.23)].
- p. Current or history of central nervous system shunts of all kinds (V45.2).
- q. Syncope or atraumatic loss of consciousness. History of recurrent syncope or presyncope (780.2), including blackout, fainting, loss or alteration of level of consciousness (excludes single episodes of vasovagal reaction with identified trigger such as venipuncture), unless there has been no recurrence during the

preceding two (2) years while off all medication for treatment of this condition.

32. Sleep Disorders.

- a. Chronic insomnia (780.5). Within the past year, had difficulty sleeping, or used medication to promote sleep for more than three (3) nights per week, over a three (3) month period.
- b. Sleep related breathing disorders (327). Current diagnosis or treatment of sleep-related breathing disorders, including but not limited to sleep apnea (327.2).
- c. Current or history of narcolepsy, cataplexy (347-347.11), or other hypersomnia disorder (327.13-19).
- d. Circadian rhythm disorders requiring treatment (307.45).
- e. Current or history of parasomnia (327.44, 327.49), including but not limited to sleepwalking, enuresis, or night terrors (307.46), after the age of 15.
- f. Current diagnosis or treatment of sleep-related movement disorders to include restless leg syndrome (327.5).

33. Learning Psychiatric and Behavioral.

- a. Attention Deficit Hyperactivity Disorder (ADHD) (314) UNLESS the following criteria are met:
  - (1) The applicant has not required an Individualized Education Program or work accommodations since the age of 14.
  - (2) There is no history of comorbid mental disorders.
  - (3) The applicant has never taken more than a single daily dosage of medication or has not been prescribed medication for this condition for more than 24 cumulative months after the age of 14.
  - (4) During periods off of medication after the age of 14, the applicant has been able to maintain at least a 2.0 grade point average without accommodations.
  - (5) Documentation from the applicant's prescribing provider that continued medication is not required for acceptable occupational or work performance.
  - (6) Applicant is required to enter Service and pass Service specific training periods with no prescribed medication for ADHD.

- b. History of learning disorders (315), including but not limited to dyslexia (315.02), UNLESS applicants demonstrated passing academic and employment performance without utilization or recommendation of academic and/or work accommodations at any time since age 14.
- c. Pervasive Developmental Disorders (299 series) including Asperger Syndrome, Autistic Spectrum Disorders, and Pervasive Developmental Disorder-Not Otherwise Specified (299.9).
- d. Current or history of disorders with psychotic features such as schizophrenic disorders (295), delusional disorders (297), or other and unspecified psychoses (298)
- e. History of bipolar disorders (296.4-7) and affective psychoses (296.8).
- f. History of depressive disorders including but not limited to major depression (296), dysthymic disorder (300.4), cyclothymic disorder requiring outpatient care for longer than twelve (12) months by a physician or other mental health professional (to include V65.40), or any inpatient treatment in a hospital or residential facility.
- g. Depressive disorders not otherwise specified (311), or unspecified mood disorder (296.90), unless:
  - (1) Outpatient care was not required for longer than 24 months (cumulative) by a physician or other mental health professional (to include V65.40).
  - (2) The applicant has been stable without treatment for the past 36 continuous months.
  - (3) The applicant did not require any inpatient treatment in a hospital or residential facility.
- h. History of a single adjustment disorder (309) within the previous three (3) months, or recurrent episodes of adjustment disorders.
- i. Current or history of disturbance of conduct (312), impulse control (312.3), oppositional defiant (313.81), other behavior disorders (313), or personality disorder (301).
  - (1) History (demonstrated by repeated inability to maintain reasonable adjustment in school, with employers or fellow workers, or social groups), interview, psychological testing revealing that the degree of immaturity, instability, of personality inadequacy, impulsiveness, or dependency shall likely interfere with adjustment in the Military services.

- (2) Recurrent encounters with law enforcement agencies (excluding minor traffic violations) or antisocial behaviors are tangible evidence of impaired capacity to adapt to military service.
- j. Encopresis (307.7) after 13<sup>th</sup> birthday.
- k. History of anorexia nervosa (307.1) or bulimia (307.51).
- l. Other eating disorders (307.50; 52-54) including unspecified disorders of eating (307.59) occurring after the 13<sup>th</sup> birthday.
- m. Any current receptive or expressive language disorder, including but not limited to any speech impediment or stammering and stuttering (307.0) of such a degree as to significantly interfere with production of speech or the ability to repeat commands.
- n. History of suicidal behavior, including gesture(s) or attempt(s) (300.9) or history of self-mutilation or injury used as a way of dealing with life and emotions.
- o. History of obsessive-compulsive disorder (300.3) or post traumatic stress disorder (309.81).
- p. History of anxiety disorders (300.01), anxiety disorder not otherwise specified (300.00), panic disorder (300.2), agoraphobia (300.21, 300.22), social phobia (300.23), simple phobias (300.29), other acute reactions to stress (308)  
UNLESS:
  - (1) The applicant did not require any treatment in any inpatient or residential facility.
  - (2) Outpatient care was not required for longer than 12 months (cumulative) by a physician or other mental health professional (to include V65.40).
  - (3) The applicant has not required treatment (including medication) for the past 24 continuous months.
  - (4) The applicant has been stable without loss of time from normal pursuits for repeated periods even if of brief duration; and without symptoms or behavior of a repeated nature that impaired social, school, or work efficiency for the past 24 continuous months.
- q. Current or history of dissociative, conversion, or factitious disorder (300.1), depersonalization (300.61), hypochondriasis (300.7), somatoform disorders (300.8), or pain disorder related to psychological factors (307.80 and .89).



- r. Current or history of psychosexual conditions (302), including but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias.
- s. Current or history of alcohol dependence (303), drug dependence (304), alcohol abuse (305.0), or other drug abuse (305.2 thru 305.9).
- t. Current or history of other mental disorders (all 290-319 not listed) that, in opinion of the civilian or military medical examiner, shall interfere with or prevent satisfactory performance of military duty.
- u. Prior psychiatric hospitalization for any cause.

34. Tumors and Malignancies.

- a. Current benign tumors or conditions that interfere with function, prevent the proper wearing of the uniform or protective equipment, shall require frequent specialized attention, or have a high malignant potential, such as Dysplastic Nevus Syndrome.
- b. Current or history of malignant tumors (V10).
- c. Skin cancer (other than malignant melanoma) removed with no residual DOES meet the standard.

35. Miscellaneous.

- a. Current or history of parasitic diseases, if symptomatic or carrier state, including but not limited to filariasis (125), trypanosomiasis (086), schistosomiasis (120), hookworm (uncinariasis) (126.9), unspecified infectious and parasitic disease (136.9).
- b. Current or history of other disorders, including but not limited to cystic fibrosis (277.0), or porphyria (277.1), that prevent satisfactory performance of duty or require frequent or prolonged treatment.
- c. Current or history of cold-related disorders, including but not limited to frostbite, chilblain, immersion foot (991), or cold urticaria (708.2).
- d. Current residual effects of cold-related disorders (991.9), including but not limited to paresthesias, easily traumatized skin, cyanotic amputation of any digit, ankylosis, trench foot, or deep-seated ache.
- e. History of angioedema, including hereditary angioedema (277.6).
- f. History of receiving organ or tissue transplantation (V42).
- g. History of pulmonary (415) or systemic embolization (444).

- h. History of untreated acute or chronic metallic poisoning, including but not limited to lead, arsenic, silver (985), beryllium, or manganese (985.2), or current complications or residual symptoms of such poisoning.
- i. History of heat pyrexia (992.0), heatstroke (992.0), or sunstroke (992.0).
- j. History of three or more episodes of heat exhaustion (992.3).
- k. Current or history of a predisposition to heat injuries (992.0-992.8), including disorders of sweat mechanism (705.0-705.9), combined with a previous serious episode.
- l. Current or history of any unresolved sequelae of heat injury (992.0-992.8), including but not limited to nervous, cardiac, hepatic or renal systems.
- m. Current or history of any condition that in the opinion of the Medical Officer shall significantly interfere with the successful performance of military duty or training (should use specific ICD code whenever possible or 796.9).
- n. Any current acute pathological condition, including but not limited to acute communicable diseases, until recovery has occurred without sequelae.

**Figure 3-D-1****Evaluation for Risk of Head Injury Sequelae**

<b>DEGREE OF HEAD INJURY</b>	<b>MINIMUM REQUIRED WAITING PERIOD</b>	<b>EVALUATION REQUIREMENTS</b>
MILD	ONE MONTH	COMPLETE NEUROLOGICAL EXAMINATION BY A PHYSICIAN
MODERATE	TWO YEARS	COMPLETE NEUROLOGICAL EVALUATION BY A NEUROLOGIST OR INTERNIST CT SCAN
SEVERE	PERMANENT DISQUALIFICATION	COMPLETE NEUROLOGICAL EVALUATION BY NEUROLOGIST OR NEUROSURGEON CT SCAN NEUROPSYCHOLOGICAL EVALUATION

**Figure 3-D-2**  
**Classification and Comparative Nomenclature of Cervical Smears**

Original Classification	CIN System	Bethesda System
Class I: No abnormal cells	Normal smear;	
Class II: Atypical cells present below the level of cervical neoplasia		Atypical squamous cells of undetermined significance
Class III: Smear contains abnormal cells consistent with dysplasia	Mild dysplasia = CIN1 Moderate dysplasia = CIN2	Low-grade SIL (Changes associated with HPV & CIN1)
Class IV: Smear contains abnormal cells consistent with carcinoma-in-situ	Severe dysplasia and carcinoma-in-situ = CIN3	High-grade SIL (CIN2, CIN3, and carcinoma-in-situ)
Class V: Smear contains abnormal		Squamous cell carcinoma
1. cells consistent with carcinoma		
2. squamous cell carcinoma		

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Abbreviations: CIN = cervical intraepithelial neoplasia  
SIL = squamous intraepithelial lesion

E. Physical Standards for Programs Leading to Commission.

1. Appointment as Cadet, USCG Academy.

a. Physical Examinations.

- (1) Applicants are encouraged to review the physical standards as published in the Academy Bulletin with their private physician prior to submitting their application for cadet candidate. This review serves to rule out, at this stage of the potential cadet's processing, applicants who obviously will not meet the required physical standards for appointment. In some cases, the physician may recommend a complete physical examination. Inaccuracy in ascertaining defects and determining the candidate's physical status at the time of this review results in unnecessary work for the CG and disappointment to the candidate when defects are subsequently found during the formal physical examination.
- (2) Candidates and their parents and sponsors are urged to refrain from requesting waivers for medical defects. The CG bases its decision to disqualify an individual on medical facts revealed in a thorough physical examination. Candidates unable to satisfy the minimum requirements are not suited for commission in the Regular CG, and consequently are not eligible for training at the Academy. A request for waiver for a medical defect invariably results in disappointment to all concerned.
- (3) Two physical examinations are required:
  - (a) Formal physical examination before appointment is tendered.
  - (b) Pre-training examination at the time of reporting to the Academy.
- (4) Formal physical examinations prior to accepting of candidates must be performed by a U. S. Public Health Service, Navy, Army, Air Force, or Veteran's Administration Medical Officer authorized to perform each exam by Department of Defense Medical Examination Review Board (DODMERB). All candidates are instructed where to report for such examinations.

b. Physical Standards. All candidates for the CG Academy must meet the physical standards for enrollment as an officer candidate. DODMERB is reviewing authority.

c. Retention. The standards for retention of a cadet at the Academy are the same as those for enrollment as an officer candidate, except that the Superintendent of the Academy is authorized to establish physical fitness and weight control programs designed to have cadets maintain weight closer to the ideal than the standards stipulated elsewhere for Service

personnel. These stricter goals during cadet years are intended to take advantage of the Academy's unique environment of rigorous physical activity combined with opportunities for diet control and weight monitoring. These programs will instill lifelong behavior patterns to support the Service weight control standards.

2. Commissioning of Cadets. The pre-appointment physical examination of cadets in the graduating class should be held at least 6 months prior to acceptance of the commission. This physical examination should be conducted to determine physical fitness for commission in the Regular Service (Section 3-D and 3-E) with recommendations made accordingly. Cadets should not be summarily disqualified for commissioning merely because they do not meet the standards for appointment as cadets provided that they may reasonably be expected to be physically capable of completing a full and effective CG career. In general, relatively minor defects that would be disqualifying for original commission direct from civilian life are not disqualifying for commission of a cadet in whom the Government has a considerable investment.

3. Enrollment as an Officer Candidate.

- a. Physical Examination. The physical examination for an officer candidate must be conducted by a Medical Officer and a Dentist. Particular care must be exercised during the examination in order that candidates may not be rejected later as a result of reexamination at Officer Candidate School. A complete physical examination is given officer candidates upon arrival at OCS to determine medical fitness and freedom from disease. Physician Assistant Officer Candidates will only receive an initial OCS candidate physical.

- b. Physical Standards for Enrollment. The standards contained in Section 3-D (Section 3-F for enlisted OCS candidates), as modified below, are applicable for enrollment as an officer candidate. Conditions not enumerated, that in the medical examiner's opinion will not permit a full productive career, shall be recorded in detail with appropriate recommendations.

- (1) Distant Visual Acuity. Uncorrected visual acuity shall be not worse than 20/400 in either eye provided that vision is correctable to 20/20 and that refractive error does not exceed plus or minus 8.0 diopters spherical equivalent (sphere + 1/2 cylinder), astigmatism does not exceed 3.00 diopters, and anisometropia does not exceed 3.50 diopters. Eyes must be free from any disfiguring or incapacitating abnormality and from acute or chronic disease. All personnel requiring corrective lenses shall wear them for the performance of duty.
- (2) Near visual acuity of any degree that does not correct to 20/40 in the better eye.
- (3) Normal color perception.

## (4) Teeth.

- (a) All candidates shall be given a Type II dental examination by a dental officer, as part of the pre-training physical examination.
- (b) Caries. No more than four teeth may exhibit multi-surface caries.
- (c) Endodontics. The need for endodontic intervention on seven or more canals is disqualifying.
- (d) Maxillary and Mandibular Bones. Malunited fractures of maxillary or mandibular bones and deformities of maxillary or mandibular bones interfering with mastication or speech are disqualifying. The presences of extensive necrosis or osseous lesions requiring surgical intervention are also disqualifying.
- (e) Oral Tissues. Extensive loss of oral tissues that would prevent the replacement of missing teeth with a satisfactory prosthetic appliance is disqualifying. Unresolved oral inflammatory diseases are disqualifying. Hypertrophic, hyperplastic, or leukoplakic conditions of the soft tissue of the oral cavity may be disqualifying and will be considered on a case-by-case basis.
- (f) Periodontal Disease. The presence of advanced periodontal disease is disqualifying.
- (g) Serviceable Teeth. A sufficient number of teeth, natural or artificial, in functional occlusion to assure satisfactory incision, mastication, and phonation are required. The minimum requirement is edentulous upper and lower jaws corrected by full dentures. A requirement for placement of a prosthesis to meet the above requirements is disqualifying.
- (h) Temporomandibular Joint. Current symptoms and/or history of chronic temporomandibular joint dysfunction is disqualifying (see also Section 3-D-16.b).
- (i) Orthodontics. Candidates with active appliances will need to submit a waiver request for continuing active orthodontic treatment as described in Section 2-A-3-e of this Manual.

4. Commissioning of Officer Candidates.

- a. The physical examination given upon arrival at OCS precludes the need for a commissioning physical examination providing there has been no intervening change in physical status and a visual acuity and color perception examination are given prior to actual commissioning.

- b. The physical standards for commissioning are the same as for enrollment as an officer candidate. Final determination as to physical fitness for commissioning is made by the Commandant.
- 5. CG Direct Commission Program. Physical standards for CG active duty members (CWOs and Enlisted) that apply for the Direct Commission program are the same as for retention of officers in the regular CG. Refer to Section F of this Manual for the standards. Physical standards for all other applicants are the same as for enrollment of officer candidates.
- 6. Direct Commission in the CG Reserve.
  - a. Non-aviator. The physical examination and standards for direct commission in the Reserve are the same for enrollment of officer candidates, except that Ready Reserve Direct Commission (RRDC) examinations must be within 24 months prior to the date of execution of the Acceptance and Oath of Office (CG-9556).
  - b. Aviator. Candidates for direct commission in the Reserve as aviators must obtain an aviation physical examination from a currently qualified uniformed services Flight Surgeon or AMO within the last 12 months. The candidate must meet the standards for Class I, contained in Section 3-G.
- 7. Direct Commission of Licensed Officers of U. S. Merchant Marine.
  - a. Physical Examination. Two physical examinations are required: a preliminary physical at the time of the written examination; and a pre-appointment physical examination taken by successful candidates within six months of actual commission. The physical examination must be conducted by a Medical Officer of the uniformed services on active duty. Final determination of physical fitness will be made by the Commandant.
  - b. Physical Standards. The physical standards for direct commission of Licensed Officers of the U. S. Merchant Marine are the same as for enrollment of officer candidates. All these standards must be met without waiver.
- 8. Appointment to Warrant Grade.
  - a. Physical Examination. A complete physical examination is required within 12 months prior to appointment to Warrant Officer, except that physical examinations for members of the CG Ready Reserve must be within 24 months prior to the date of execution of the Acceptance and Oath of Office, Form CG-9556.
  - b. Physical Requirements. The physical standards for appointment of CG members to Warrant Officer are the same as for retention of officers in the regular CG. Refer to Section 3-F of this Manual for the standards. Physical

standards for all other applicants are the same as for enrollment of officer candidates.



F. Physical Standards Applicable to All Personnel (Regular and Reserve) For: Reenlistment; Enlistment of Prior Service USCG Personnel; Retention; Overseas Duty; and Sea Duty.

1. General Instructions.

- a. Scope. This section establishes specific physical standards applicable to all personnel (regular and reserve) for:
    - (1) Enlistment/reenlistment of prior service USCG personnel within 6 months of discharge from active duty in the regular CG.
    - (2) Retention.
    - (3) Overseas duty.
    - (4) Sea duty.
  - b. Physical Examinations. Physical examinations should be conducted by at least one Medical and one Dental Officer of the uniformed services or by contract physician/dentist.
  - c. Fitness for Duty. Members are ordinarily considered fit for duty unless they have a physical impairment (or impairments) that interferes with the performance of the duties of their grade or rating. A determination of fitness or unfitness depends upon the individual's ability to reasonably perform those duties. Active duty or reserves on extended active duty considered permanently unfit for duty shall be referred to a Medical Evaluation Board (MEB) for appropriate disposition. Reservists in any status not found 'fit for duty' six months after incurring/aggravating an injury or illness, or reservists who are unlikely to be found 'fit for duty' within six months after incurring/aggravating an injury or illness shall be referred to a Medical Evaluation Board. See Reserve Policy Manual, COMDTINST M1001.28 (series), Chapter 6, "Reserve Incapacitation System".
2. Use of List of Disqualifying Conditions and Defects. This section lists certain medical conditions and defects that are normally disqualifying. However, it is not an all-inclusive list. Its major objective is to achieve uniform disposition of cases arising under the law, but it is not a mandate that possession of one or more of the listed conditions or physical defects (and any other not listed) means automatic retirement or separation. If the member's condition is disqualifying but he/she can perform his/her duty, a waiver request could be submitted in lieu of immediate referral to a Medical Evaluation Board. If the request is denied, then a Medical Evaluation Board is required. The only exception is HIV infection, which may not require waiver or referral to MEB if the member continues to fully perform duties. (see Chapter 3- F-22 of this Manual).

3. Head and Neck.

- a. Loss of substance of the skull including face. With or without prosthetic replacement when accompanied by moderate residual signs and symptoms or when interfering with proper wear of PPE.
- b. Torticollis (wry neck). Severe fixed deformity with cervical scoliosis, flattening of the head and face, and loss of cervical mobility.

4. Esophagus, Nose, Pharynx, Larynx, and Trachea.

a. Esophagus.

- (1) Achalasia. Manifested by dysphagia (not controlled by dilation), frequent discomfort, inability to maintain normal vigor and nutrition, or requiring frequent treatment.
- (2) Esophagitis. Persistent and severe.
- (3) Diverticulum of the esophagus. Of such a degree as to cause frequent regurgitation, obstruction and weight loss that does not respond to treatment.
- (4) Stricture of the esophagus. Of such a degree as to almost restrict diet to liquids, require frequent dilation and hospitalization, and cause difficulty in maintaining weight and nutrition.

b. Larynx.

- (1) Paralysis of the larynx. Characterized by bilateral vocal cord paralysis seriously interfering with speech or adequate airway.
- (2) Stenosis of the larynx. Causing respiratory embarrassment upon more than minimal exertion.
- (3) Obstruction/edema of glottis. If chronic, not amenable to treatment and requiring tracheotomy.

c. Nose, Pharynx, Trachea.

- (1) Rhinitis. Atrophic rhinitis characterized by bilateral atrophy of nasal mucous membrane with severe crusting and concomitant severe headaches.
- (2) Sinusitis. Severe and chronic that is suppurative, complicated by polyps, and does not respond to treatment.
- (3) Trachea. Stenosis of trachea that compromises airflow to more than a mild degree.

5. Eyes.

a. Diseases and Conditions.

- (1) Active eye disease or any progressive organic disease regardless of the stage of activity, that is resistant to treatment and affects the distant visual acuity or visual field so that the member fits into one of the following:

- (a) Distant visual acuity does not meet the standards.
- (b) The diameter of the field of vision in the better eye is less than 20°.
- (2) Aphakia, bilateral. Regardless of lens implant(s).
- (3) Atrophy of optic nerve.
- (4) Glaucoma. If resistant to treatment, or affecting visual fields, or if side effects of required medications are functionally incapacitating.
- (5) Diseases and infections of the eye. When chronic, more than mildly symptomatic, progressive and resistant to treatment after a reasonable period.
- (6) Ocular manifestations of endocrine or metabolic disorders. Not disqualifying, per se; however, residuals or complications, or the underlying disease may be disqualifying.
- (7) Residuals or complications of injury. When progressive or when reduced visual acuity or fields do not meet the standards.
- (8) Retina, detachment of.
  - (a) Unilateral.
    - [1] When visual acuity does not meet the standards.
    - [2] When the visual field in the better eye is constricted to less than 20°.
    - [3] When uncorrectable diplopia exists.
    - [4] When detachment results from organic progressive disease or new growth, regardless of the condition of the better eye.
  - (b) Bilateral. Regardless of etiology or results of corrective surgery.

b. Vision.

- (1) Aniseikonia. Subjective eye discomfort, neurologic symptoms, sensations of motion sickness and other gastrointestinal disturbances, functional disturbances and difficulties in form sense, and not corrected by iseikonic lenses.
- (2) Binocular diplopia. Which is severe, constant, and in zone less than 20° from the primary position.
- (3) Hemianopsia. Of any type, if bilateral, permanent, and based on an organic defect. Those due to a functional neurosis and those due to transitory conditions, such as periodic migraine, are not normally disqualifying.
- (4) Night blindness. Of such a degree that the individual requires assistance in any travel at night.
- (5) Visual Acuity.

- (a) Visual acuity that cannot be corrected to at least 20/50 in the better eye.
    - (b) Complete blindness or enucleation of an eye.
    - (c) When vision is correctable only by the use of contact lenses or other corrective device (telescope lenses, etc.).
  - (6) Visual Fields. When the visual field in the better eye is constricted to less than 20°.
  - (7) Color Perception. Normal color perception is required for retention of commissioned officers (certain Warrant Officer specialties do not require normal color perception) and selected ratings [See Officer Accessions, Evaluations, and Promotions, COMDTINST M1000.3 (series) and Enlisted Accessions, Evaluations, and Advancements, COMDTINST M1000.2 (series)]. The testing for color vision must be unaided or with standard corrective lenses only. Use of any lenses (such as Chromagen) or other device to compensate for defective color vision is prohibited. Retesting of color vision is required as a component of any other vision screening or assessment. Exception: At the time of accession medical screening (e.g. CG Academy (including cadets and OCS candidates), Cape May recruits) the PIP color vision test will be repeated and normal color vision confirmed under controlled conditions as described in Chapter 3 Section C 22.i of this Manual. Examinees are qualified if they pass either the Pseudoisochromatic Plates (PIP) or the Farnsworth Lantern (FALANT) test. Examinees who fail the PIP are qualified if they pass the FALANT.
- c. Corneal Refractive Surgery.
- (1) The refractive surgery procedures radial keratotomy (RK), and intracorneal rings (ICR) are disqualifying.
  - (2) Corneal Refractive Surgery for aviation personnel and candidates is discussed in the Aviation Medicine Manual, COMDTINST M6410.3 (series).
  - (3) Photorefractive keratectomy (PRK) or Laser Assisted in situ Keratomileusis (LASIK) is not disqualifying for non-aviation members, including diving personnel, and does not require a waiver if the following conditions are met:
    - (a) Must follow guidelines for elective health care contained in this manual. Note: Personnel having any type of corneal refractive surgery shall not perform duties requiring stable eyesight (e.g. deck watch, boat crew, etc.) until medically cleared.
    - (b) There must be post surgical refractive stability defined as less than 0.50 diopter changes over two separate exams at least three months apart.
    - (c) Must meet all vision standards in 3-F.5.b (divers must meet vision standards in 3-H.2.h). If the member is unable to meet these standards they will be considered for administrative separation.

- (4) Implantable Contact Lenses (ICL) are not disqualifying and do not need a waiver if the following conditions are met: (Does not apply to aviation personnel)
  - (a) Must follow guidelines for elective health care contained in this manual.
  - (b) Must meet retention vision standards by three months post operatively.
- (5) Recommended Wait Times for Activities after Refractive Surgery.
  - (a) LASIK: The greatest risk after LASIK is flap dislocation. Avoid activities that might cause trauma to the flap.
  - (b) PRK: The greatest risk after PRK is corneal surface irritation and haze. During the first 3-4 months after surgery, avoid activities that might irritate the surface of your eyes, and avoid exposure to ultraviolet (UV) light by wearing sunglasses when outdoors during the day.
  - (c) ICL: The greatest risk after ICL is infection inside the eye. Avoid lifting or bending over, trauma to the eye, and avoid activities that increase infection risk such as swimming and gardening.

FIGURE 3-F-1  
Recommended Wait Times for Activities after Refractive Surgery

	ICL	LASIK	PRK
Showering or washing face.	No restriction. Notes: You should always avoid getting water in the eyes and pat the eyes dry		
Air travel as a passenger	3 days		5-7 days (after removal of bandage contact lens)
Aerobic activity (walk, run, bike, exercise machines) or weight training. Notes: Avoid getting sweat, dust, or wind in eyes.	2 weeks	As soon as pain and light sensitivity have resolved: 1-2 days.	As soon as pain and light sensitivity have resolved: 3-5 days.
Bending over(toe touches, sit-ups)	2 weeks	No restriction.	
Contact sports: Martial arts, basketball, boxing, wrestling	1 month. Note: There is a lifelong risk of opening surgical wounds with trauma to the eye. If you resume these activities, you must wear eye protection.		1 month.
Exposure to hot tubs, pools, lakes, ocean, river	1 month Note: Risk of infection from contaminated water		
Wearing eye make-up, including camouflage face paint	2 weeks Note: Infection risk from contaminated make-up. When make-up use is resumed, start with new, freshly opened products. Old eye makeup should be discarded.		
Working in a dusty or dirty environment: outdoor rifle range, deploying to the field, gardening	1 month	2 weeks	1 month
CS exposure (gas chamber) or OC spray (pepper spray) exposure	3 months		6 months
Driving an automobile or motorcycle with goggles or face shield	When you meet the driving vision requirement and feel comfortable.		
Wearing UV protection (sunglasses)	Wear UV protection whenever practical.		Full time first month As much as possible the 2 <sup>nd</sup> -4 <sup>th</sup> months and whenever practical afterwards.

## 6. Ears and Hearing.

### a. Ears.

- (1) Infections of the external auditory canal. Chronic and severe, resulting in thickening and excoriation of the canal, or chronic secondary infection requiring frequent and prolonged medical treatment and hospitalization
- (2) Malfunction of the acoustic nerve. Evaluate hearing impairment.
- (3) Mastoiditis, chronic. Constant drainage from the mastoid cavity, requiring frequent and prolonged medical care.
- (4) Mastoidectomy. Followed by chronic infection with constant or recurrent drainage requiring frequent or prolonged medical care.
- (5) Meniere's syndrome. Recurring attacks of sufficient frequency and severity as to interfere with satisfactory performance of military duty, or require frequent or prolonged medical care.
- (6) Otitis Media (chronic or recurrent). Moderate, chronic, suppurative, resistant to treatment, and necessitating frequent or prolonged medical care.

### b. Hearing. Retention will be determined on the basis of ability to perform duties of grade or rating.

## 7. Lungs and Chest Wall.

### a. Tuberculous (TB) Lesions. See <http://www.cdc.gov/tb/>.

#### (1) Pulmonary tuberculosis.

- (a) When an active duty member's disease is found to be not incident to military service, or when treatment and return to useful duty will probably require more than 15 months, including an appropriate period of convalescence, or if expiration of service will occur before completion of period of hospitalization. (Career members who express a desire to reenlist after treatment may extend their enlistment to cover period of hospitalization.)
- (b) When a Reservist not on active duty has TB that will probably require treatment for more than 12 to 15 months including an appropriate period of convalescence before being able to perform full-time military duty. Individuals who are retained in the Reserve while undergoing treatment may not be called or ordered to active duty (including mobilization), active duty for training, or inactive duty training during the period of treatment and convalescence.

### b. Non-tuberculous Conditions. Pulmonary diseases, other than acute infections, must be evaluated in terms of respiratory function, manifested clinically by measurements that must be interpreted as exertional or altitudinal tolerance. Symptoms of cough, pain, and recurrent infections may limit a member's activity.

Many of the conditions listed below may coexist and in combination may produce unfitness.

- (1) Atelectasis, or massive collapse of the lung. Moderately symptomatic with paroxysmal cough at frequent intervals throughout the day, or with moderate emphysema, or with residuals or complications that require repeated hospitalization.
- (2) Bronchial Asthma. Associated with emphysema of sufficient severity to interfere with the satisfactory performance of duty, or with frequent attacks not controlled by inhaled or oral medications, or requiring oral corticosteroids more than twice a year.
- (3) Bronchiectasis or bronchiolectasis. Cylindrical or saccular type that is moderately symptomatic, with productive cough at frequent intervals throughout the day, or with moderate other associated lung disease to include recurrent pneumonia, or with residuals or complications that require repeated hospitalization.
- (4) Bronchitis. Chronic, severe persistent cough, with considerable expectoration, or with moderate emphysema, or with dyspnea at rest or on slight exertion, or with residuals or complications that require repeated hospitalization.
- (5) Cystic disease of the lung, congenital. Involving more than one lobe of a lung.
- (6) Diaphragm, congenital defect. Symptomatic.
- (7) Hemopneumothorax, hemothorax, or pyopneumothorax. More than moderate pleuritic residuals with persistent underweight, or marked restriction of respiratory excursion and chest deformity, or marked weakness and fatigability on slight exertion.
- (8) Histoplasmosis. Chronic and not responding to treatment.
- (9) Pleurisy, chronic or pleural adhesions. Severe dyspnea or pain on mild exertion associated with definite evidence of pleural adhesions and demonstrable moderate reduction of pulmonary function.
- (10) Pneumothorax, spontaneous. Repeated episodes of pneumothorax not correctable by surgery.
- (11) Pneumoconiosis. Severe with dyspnea on mild exertion.
- (12) Pulmonary calcification. Multiple calcifications associated with significant respiratory embarrassment or active disease not responsive to treatment.
- (13) Pulmonary emphysema. Marked emphysema with dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.
- (14) Pulmonary fibrosis. Linear fibrosis or fibrocalcific residuals that cause dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.
- (15) Pulmonary sarcoidosis. If not responding to therapy and complicated by demonstrable moderate reduction in pulmonary function.



- (16) Stenosis, bronchus. Severe stenosis associated with repeated attacks of bronchopulmonary infections requiring frequent hospitalization.
  - (17) Obstructive Sleep Apnea. When not correctable by use of CPAP or surgical means.
  - c. Surgery of the Lungs and Chest. Lobectomy. If pulmonary function (ventilatory tests) is impaired to a moderate degree or more.
8. Heart and Vascular System.
- a. Heart.
    - (1) Arrhythmias. Associated with organic heart disease, or if not adequately controlled by medication or if they interfere with satisfactory performance of duty.
    - (2) Arteriosclerotic disease. Associated with congestive heart failure, repeated anginal attacks, or objective evidence of myocardial infarction.
    - (3) Endocarditis. Bacterial endocarditis resulting in myocardial insufficiency or associated with valvular heart disease.
    - (4) Heart block. Associated with other symptoms of organic heart disease or syncope (Stokes-Adams Syndrome).
    - (5) Myocarditis and degeneration of the myocardium. Myocardial insufficiency resulting in slight limitation of physical activity.
    - (6) Hypertrophic myocardial disease. If resulting in hemodynamic stability or not resolved by surgery.
    - (7) Pericarditis.
      - (a) Chronic constrictive pericarditis unless successful remedial surgery has been performed.
      - (b) Chronic serous pericarditis.
    - (8) Rheumatic valvulitis and valvular heart disease. Cardiac insufficiency at functional capacity and therapeutic level of class IIC or worse, American Heart Association. A diagnosis made during the initial period of service or enlistment that is determined to be a residual of a condition that existed prior to entry in the service is disqualifying regardless of severity.
  - b. Vascular System.
    - (1) Arteriosclerosis obliterans. When any of the following pertain:
      - (a) Intermittent claudication of sufficient severity to produce pain and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without a rest.

- (b) Objective evidence of arterial disease with symptoms of claudication, ischemic chest pain at rest, or with gangrenous or permanent ulcerative skin changes in the distal extremity.
  - (c) Involvement of more than one organ system or anatomic region (the lower extremities comprise one region for this purpose) with symptoms of arterial insufficiency.
- (2) Congenital anomalies. Coarctation of aorta and other congenital anomalies of the cardiovascular system unless satisfactorily treated by surgical correction.
- (3) Aneurysms. Aneurysm of any vessel not correctable by surgery and producing limiting symptomatic conditions precluding satisfactory performance of duty. Aneurysm corrected by surgery but with residual limiting symptomatic conditions that preclude satisfactory performance of duty.
  - (a) Satisfactory performance of duty is precluded because of underlying recurring or progressive disease producing pain, dyspnea, or similar symptomatic limiting conditions.
    - [1] Reconstructive surgery including grafts, when prosthetic devices are attached to or implanted in the heart.
    - [2] Unproven procedures have been accomplished and the patient is unable to satisfactorily perform duty or cannot be returned to duty under circumstances permitting close medical supervision.
- (4) Periarteritis nodosa. With definite evidence of functional impairment.
- (5) Chronic venous insufficiency (postphlebotic syndrome). When more than mild and symptomatic despite elastic support.
- (6) Raynaud's phenomenon. Manifested by trophic changes of the involved part characterized by scarring of the skin or ulceration.
- (7) Thrombophlebitis. When repeated attacks require such frequent treatment as to interfere with satisfactory performance of duty.
- (8) Varicose veins. Severe and symptomatic despite therapy.
- (9) Any condition requiring anti-thrombotic medication other than aspirin.
- c. Miscellaneous.
  - (1) Erythromelalgia. Persistent burning pain in the soles or palms not relieved by treatment.
  - (2) Hypertensive cardiovascular disease and hypertensive vascular disease.
    - (a) Diastolic pressure consistently more than 90 mm Hg following an adequate period of therapy on an ambulatory status; or,

- (b) Any documented history of hypertension regardless of the pressure values if associated with one or more of the following:

- [1] Cerebrovascular symptoms.

- [2] Arteriosclerotic heart disease if symptomatic and requiring treatment.

- [3] Kidney involvement, manifested by unequivocal impairment of renal function.

- [4] Grade III (Keith-Wagener-Barker) changes in the fundi.

- (3) Rheumatic fever, active, with or without heart damage. Recurrent attacks.

- (4) Residual of surgery of the heart, pericardium, or vascular system under one or more of the following circumstances:

- (a) When surgery of the heart, pericardium, or vascular system results in inability of the individual to perform duties without discomfort or dyspnea.

- (b) When the surgery involves insertion of a pacemaker, reconstructive vascular surgery employing exogenous grafting material.

- (c) Similar newly developed techniques or prostheses, the individual is unfit.

## 9. Abdomen and Gastrointestinal System.

### a. Defects and Diseases.

- (1) Achalasia. Manifested by dysphagia not controlled by dilation with frequent discomfort, or inability to maintain normal vigor and nutrition.
- (2) Amebic abscess residuals. Persistent abnormal liver function tests and failure to maintain weight and normal vigor after appropriate treatment.
- (3) Biliary dyskinesia. Frequent abdominal pain not relieved by simple medication, or with periodic jaundice.
- (4) Cirrhosis of the liver. Recurrent jaundice or ascites; or demonstrable esophageal varices or history of bleeding there from.
- (5) Erosive esophagitis. Confirmed by gastroscopy, chronic with repeated symptomatology, not relieved by medication or surgery.
- (6) Gastritis. Severe, chronic gastritis with repeated symptomatology and hospitalization and confirmed by gastroscopic examination.
- (7) Hepatitis, chronic. When, after a reasonable time (1 to 2 years) following the acute stage, symptoms persist, and there is objective evidence of impaired liver function.
- (8) Malabsorption syndrome. When normal nutrition cannot be maintained despite replacement therapy.

- (9) Surgical absence of >50% small or large intestine or <50% with inability to maintain normal vigor or nutrition.
  - (10) Recurrent cholelithiasis. When resulting in bouts of cholecystitis or pancreatitis and failing dietary/medication therapy.
  - (11) Hernia.
    - (a) Hiatus hernia. Severe symptoms not relieved by dietary or medical therapy, or recurrent bleeding in spite of prescribed treatment.
    - (b) Other. If operative repair is contraindicated for medical reasons or when not amenable to surgical repair.
  - (12) Ileitis, regional (Crohn's disease). Except when responding well to ordinary treatment other than oral corticosteroids or immune-suppressant medications.
  - (13) Pancreatitis, chronic. Frequent severe abdominal pain; or steatorrhea or disturbance of glucose metabolism requiring hypoglycemic agents.
  - (14) Peritoneal adhesions. Recurring episodes of intestinal obstruction characterized by abdominal colicky pain, vomiting, and intractable constipation requiring frequent hospital admissions.
  - (15) Proctitis, chronic. Moderate to severe symptoms of bleeding, or painful defecation, tenesmus, and diarrhea, with repeated hospital admissions.
  - (16) Ulcer, peptic, duodenal, or gastric. Repeated incapacitation or absences from duty because of recurrence of symptoms (pain, vomiting, or bleeding) in spite of good medical management, and supported by laboratory, x-ray, and endoscopic evidence of activity.
  - (17) Ulcerative colitis. Except when responding well to ordinary treatment.
  - (18) Rectum, stricture of. Severe symptoms of obstruction characterized by intractable constipation, pain on defecation, difficult bowel movements requiring the regular use of laxatives or enemas, or requiring repeated hospitalization.
- b. Surgery.
- (1) Colectomy, partial. When more than mild symptoms of diarrhea remain or if complicated by colostomy.
  - (2) Colostomy. When permanent.
  - (3) Enterostomy. When permanent.
  - (4) Gastrectomy.
    - (a) Total.

- (b) Subtotal, with or without vagotomy, or gastrojejunostomy, when, in spite of good medical management, the individual develops one of the following:

- [1] "Dumping syndrome" that persists for 6 months postoperatively.
- [2] Frequent episodes of epigastric distress with characteristic circulatory symptoms or diarrhea persisting 6 months postoperatively.
- [3] Continues to demonstrate significant weight loss 6 months postoperatively. Preoperative weight representative of obesity should not be taken as a reference point in making this assessment.
- [4] Not to be confused with "dumping syndrome," and not ordinarily considered as representative of unfitness are: postoperative symptoms such as moderate feeling of fullness after eating; the need to avoid or restrict ingestion of high carbohydrate foods; the need for daily schedule of a number of small meals with or without additional "snacks."

- (5) Gastrostomy. When permanent.
- (6) Ileostomy. When permanent.
- (7) Pancreatectomy.
- (8) Pancreaticoduodenostomy, pancreaticogastrostomy, pancreaticojejunostomy. Followed by more than mild symptoms of digestive disturbance, or requiring insulin.
- (9) Proctectomy.
- (10) Proctopexy, proctoplasty, proctorrhaphy, or proctotomy. If fecal incontinence remains after appropriate treatment.
- (11) Bariatric Surgery and all other forms of weight loss surgery are not authorized. A waiver may be granted for individuals who have had surgery prior to 1 July 2007 and remain world wide deployable. Any complications arising from this surgery that would compromise fitness for duty or world wide deployment may result in separation as a result of PDES action or administrative separation regardless of previously granted waivers

10. Endocrine and Metabolic Conditions (Diseases).

- a. Acromegaly. With function impairment.
- b. Adrenal hyperfunction. That does not respond to therapy satisfactorily or where replacement therapy presents serious problems in management.
- c. Adrenal hypofunction. Requiring medication for control.
- d. Diabetes Insipidus. Unless mild, with good response to treatment.

- e. Diabetes Mellitus. When requiring insulin or not adequately controlled by oral medications (per current American Diabetes Association Standards). Waivers will be considered on a case-by-case basis for the use of non-insulin injectable medications e.g. Exenatide.
- f. Goiter. With symptoms of breathing obstruction with increased activity, unless correctable.
- g. Gout. With frequent acute exacerbations in spite of therapy, or with severe bone, joint, or kidney damage.
- h. Hyperinsulinism. When caused by a malignant tumor, or when the condition is not readily controlled.
- i. Hyperparathyroidism. When residuals or complications of surgical correction such as renal disease or bony deformities preclude the reasonable performance of military duty.
- j. Hyperthyroidism. Severe symptoms, with or without evidence of goiter, that do not respond to treatment.
- k. Hypoparathyroidism. With objective evidence and severe symptoms not controlled by maintenance therapy.
- l. Hypothyroidism. With objective evidence and severe symptoms not controlled by medication.
- m. Osteomalacia. When residuals after therapy preclude satisfactory performance of duty.

11. Genitourinary System.

- a. Genitourinary conditions.
  - (1) Cystitis. When complications or residuals of treatment themselves preclude satisfactory performance of duty.
  - (2) Dysmenorrhea. Symptomatic, irregular cycle, not amenable to treatment, and of such severity as to necessitate recurrent absences of more than 1 day/month.
  - (3) Endometriosis. Symptomatic and incapacitating to degree that necessitates recurrent absences of more than 1 day/month.
  - (4) Hypospadias. Accompanied by chronic infection of the genitourinary tract or instances where the urine is voided in such a manner as to soil clothes or surroundings, and the condition is not amenable to treatment.
  - (5) Incontinence of urine. Due to disease or defect not amenable to treatment and so severe as to necessitate recurrent absences from duty.
  - (6) Menopausal syndrome, physiologic or artificial. With more than mild mental and constitutional symptoms.
  - (7) Strictures of the urethra or ureter. Severe and not amenable to treatment.

- (8) Urethritis, chronic. Not responsive to treatment and necessitating frequent absences from duty.

b. Kidney.

- (1) Calculus in kidney. Bilateral, recurrent, or symptomatic and not responsive to treatment.
- (2) Congenital abnormality. Bilateral, resulting in frequent or recurring infections, or when there is evidence of obstructive uropathy not responding to medical or surgical treatment.
- (3) Cystic kidney (polycystic kidney). When symptomatic and renal function is impaired, or if the focus of frequent infection.
- (4) Glomerulonephritis, chronic.
- (5) Hydronephrosis. More than mild, or bilateral, or causing continuous or frequent symptoms.
- (6) Hypoplasia of the kidney. Associated with elevated blood pressure or frequent infections and not controlled by surgery.
- (7) Nephritis, chronic.
- (8) Nephrosis.
- (9) Perirenal abscess. With residuals that preclude satisfactory performance of duty.
- (10) Pyelonephritis or pyelitis. Chronic, that has not responded to medical or surgical treatment, with evidence of persistent hypertension, ocular fundoscopic changes, or cardiac abnormalities.
- (11) Pyonephrosis. Not responding to treatment.

c. Genitourinary and Gynecological Surgery.

- (1) Cystectomy.
- (2) Cystoplasty. If reconstruction is unsatisfactory or if residual urine persists in excess of 50 cc or if refractory symptomatic infection persists.
- (3) Nephrectomy. When, after treatment, there is infection or pathology in the remaining kidney.
- (4) Nephrostomy. If drainage persists.
- (5) Oophorectomy. When, following treatment and convalescent period, there remain incapacitating mental or constitutional symptoms.
- (6) Penis, amputation of.
- (7) Pyelostomy. If drainage persists.
- (8) Ureterocolostomy.
- (9) Ureterocystostomy. When both ureters are markedly dilated with irreversible changes.

(10) Ureterocystostomy, cutaneous.

(11) Ureteroplasty.

(a) When unilateral procedure is unsuccessful and nephrectomy is necessary, consider on the basis of the standard for a nephrectomy.

(b) When bilateral, evaluate residual obstruction or hydronephrosis and consider unfitness on the basis of the residuals involved.

(12) Ureterosigmoidostomy.

(13) Ureterostomy. External or cutaneous.

(14) Urethrostomy. When a satisfactory urethra cannot be restored.

12. Extremities.

a. Upper.

(1) Amputations. Amputation of part or parts of an upper extremity equal to or greater than any of the following:

(a) A thumb proximal to the interphalangeal joints.

(b) Two fingers of one hand.

(c) One finger, other than the little finger, at the metacarpophalangeal joint and the thumb of the same hand at the interphalangeal joint.

(2) Joint ranges of motion. Motion that does not equal or exceed the measurements listed below. Measurements must be made with a goniometer and conform to the methods illustrated in 3-F-EXHIBIT 1.

(a) Shoulder.

[1] Forward elevation to  $90^{\circ}$  .

[2] Abduction to  $90^{\circ}$  .

(b) Elbow.

[1] Flexion to  $100^{\circ}$  .

[2] Extension to  $60^{\circ}$  .

(c) Wrist. A total range, extension plus flexion, of  $15^{\circ}$

(d) Hand. For this purpose, combined joint motion is the arithmetic sum of the motion at each of the three finger joints.



[1] An active flexor value of combined joint motions of  $135^{\circ}$  in each of two or more fingers of the same hand.

[2] An active extensor value of combined joint motions of  $75^{\circ}$  in each of the same two or more fingers.

[3] Limitation of motion of the thumb that precludes apposition to at least two finger tips.

(3) Recurrent dislocations of the shoulder. When not repairable or surgery is contraindicated.

b. Lower.

(1) Amputations.

(a) Loss of a toe or toes that precludes the ability to run, or walk without a perceptible limp, or to engage in fairly strenuous jobs.

(b) Any loss greater than that specified above to include foot, leg, or thigh.

(2) Feet.

(a) Hallux valgus. When moderately severe, with exostosis or rigidity and pronounced symptoms; or severe with arthritic changes.

(b) Pes Planus. Symptomatic more than moderate, with pronation on weight bearing that prevents wearing military shoes, or when associated with vascular changes.

(c) Talipes cavus. When moderately severe, with moderate discomfort on prolonged standing and walking, metatarsalgia, or that prevents wearing a military shoe.

(3) Internal derangement of the knee. Residual instability following remedial measures, if more than moderate; or with recurring episodes of effusion or locking, resulting in frequent incapacitation.

(4) Joint ranges of motion. Motion that does not equal or exceed the measurements listed below. Measurements must be made with a goniometer and conform to the methods illustrated in 3-F-EXHIBIT 2.

(a) Hip.

[1] Flexion to  $90^{\circ}$  .

[2] Extension to  $0^{\circ}$  .

(b) Knee.

[1] Flexion to 90° .

[2] Extension to 15°.

(c) Ankle.

[1] Dorsiflexion to 10°.

[2] Plantar Flexion to 10°.

(5) Shortening of an extremity, which exceeds two inches.

c. Miscellaneous.

(1) Arthritis.

- (a) Due to infection. Associated with persistent pain and marked loss of function with x-ray evidence and documented history of recurring incapacity for prolonged periods.
- (b) Due to trauma. When surgical treatment fails or is contraindicated and there is functional impairment of the involved joint that precludes satisfactory performance of duty.
- (c) Osteoarthritis. Severe symptoms associated with impaired function, supported by x-ray evidence and documented history of recurrent incapacity for prolonged periods.
- (d) Rheumatoid arthritis or rheumatoid myositis. Substantiated history of frequent incapacitating and prolonged periods supported by objective and subjective findings.
- (e) Seronegative Spondylarthropathies. Severe symptoms associated with impaired function, supported by X-ray evidence and documented history of recurrent incapacity for prolonged periods.

(2) Chondromalacia or Osteochondritis Dessicans. Severe, manifested by frequent joint effusion, more than moderate interference with function or with severe residuals from surgery.

(3) Fractures.

- (a) Malunion. When, after appropriate treatment, there is more than moderate malunion with marked deformity or more than moderate loss of function.
- (b) Nonunion. When, after an appropriate healing period, the nonunion precludes satisfactory performance of military duty.

- (c) Bone fusion defect. When manifested by more than moderate pain or loss of function.
- (d) Callus, excessive, following fracture. When functional impairment precludes satisfactory performance of duty and the callus does not respond to adequate treatment.

(4) Joints.

- (a) Arthroplasty. With severe pain, limitation of motion and function.
- (b) Bony or fibrous ankylosis. Severe pain involving major joints or spinal segments in an unfavorable position, or with marked loss of function.
- (c) Contracture of joint. Marked loss of function and the condition is not remediable by surgery.
- (d) Loose bodies within a joint. Marked functional impairment complicated by arthritis that precludes favorable treatment or not remediable by surgery.

(5) Muscles.

- (a) Flaccid paralysis of one or more muscles, producing loss of function that precludes satisfactory performance of duty following surgical correction or if not remediable by surgery.
- (b) Spastic paralysis of one or more muscles producing loss of function that precludes satisfactory performance of duty.

(6) Myotonia congenita.

(7) Osteitis deformans. Involvement of single or multiple bones with resultant deformities, or symptoms severely interfering with function.

(8) Osteoarthropathy, hypertrophic, secondary. Moderately severe to severe pain present with joint effusion occurring intermittently in one or multiple joints and with at least moderate loss of function.

(9) Osteomyelitis, chronic. Recurrent episodes not responsive to treatment, and involving the bone to a degree that interferes with stability and function.

(10) Tendon transplant. Fair or poor restoration of function with weakness that seriously interferes with the function of the affected part.

13. Spine, Ribs, and Sacroiliac Joints.

- a. Spina bifida. Demonstrable signs of moderate symptoms of root or cord involvement.
- b. Spondylolysis or spondylolisthesis. With more than mild symptoms resulting in repeated hospitalization or significant assignment limitation.

- c. Coxa vara. More than moderate with pain, deformity, and arthritic changes.
- d. Herniation of nucleus pulposus. More than mild symptoms following appropriate treatment or remediable measures, with sufficient objective findings to demonstrate interference with the satisfactory performance of duty.
- e. Kyphosis. More than moderate, or interfering with function, or causing unmilitary appearance.
- f. Scoliosis. Severe deformity with over two inches of deviation of tips of spinous processes from the midline.
- g. Chronic Lumbosacral spine pain. When unresponsive to therapy, not a surgical candidate, and interfering with performance of duties.

14. Skin and Cellular Tissues.

- a. Acne. Severe, unresponsive to treatment, and interfering with the satisfactory performance of duty or wearing of the uniform or other military equipment.
- b. Atopic dermatitis. More than moderate or requiring periodic hospitalization.
- c. Amyloidosis. Generalized.
- d. Cysts and tumors. See Section 3-F-20.
- e. Dermatitis herpetiformis. If fails to respond to therapy.
- f. Dermatomyositis.
- g. Dermographism. Interfering with satisfactory performance of duty.
- h. Eczema, chronic. Regardless of type, when there is more than minimal involvement and the condition is unresponsive to treatment and interferes with the satisfactory performance of duty.
- i. Elephantiasis or chronic lymphedema. Not responsive to treatment.
- j. Epidermolysis bullosa.
- k. Erythema multiforme. More than moderate and chronic or recurrent.
- l. Exfoliative dermatitis. Chronic.
- m. Fungus infections, superficial or systemic. If not responsive to therapy and interfering with the satisfactory performance of duty.
- n. Hidradenitis suppurative and folliculitis decalvans.

- o. Hyperhydrosis. Of the hands or feet, when severe or complicated by a dermatitis or infection, either fungal or bacterial, and not amenable to treatment.
  - p. Leukemia cutis and mycosis fungoides.
  - q. Lichen planus. Generalized and not responsive to treatment.
  - r. Lupus erythematosus. Chronic with extensive involvement of the skin and mucous membranes or other organ systems and when the condition does not respond to treatment.
  - s. Neurofibromatosis. If repulsive in appearance, causing gross deformity, or when interfering with satisfactory performance of duty.
  - t. Panniculitis. Relapsing febrile, nodular.
  - u. Parapsoriasis. Extensive and not controlled by treatment.
  - v. Pemphigus. Not responsive to treatment, and with moderate constitutional or systemic symptoms, or interfering with satisfactory performance of duty.
  - w. Psoriasis. Extensive and not controllable by treatment.
  - x. Radiodermatitis. If resulting in malignant degeneration at a site not amenable to treatment.
  - y. Scars and keloids. So extensive or adherent that they significantly interfere with the function of an extremity.
  - z. Scleroderma. Generalized, or of the linear type that seriously interferes with the function of an extremity or organ.
  - aa. Ulcers of the skin. Not responsive to treatment after an appropriate period of time or if interfering with satisfactory performance of duty.
  - bb. Urticaria. Chronic, severe, or not responsive to treatment.
  - cc. Xanthoma. Regardless of type, but only when interfering with the satisfactory performance of duty.
  - dd. Other skin disorders. If chronic, or of a nature that requires frequent medical care or interferes with satisfactory performance of military duty.
15. Neurological Disorders.
- a. Amyotrophic sclerosis, lateral.
  - b. Atrophy, muscular, myelopathic. Includes severe residuals of poliomyelitis.

- c. Atrophy, muscular. Progressive muscular atrophy.
- d. Chorea. Chronic and progressive.
- e. Convulsive disorders. (This does not include convulsive disorders caused by, and exclusively incident to the use of, alcohol.) Following a seizure, the member is NFFD, and will remain unfit until he/she is controlled with medications with no seizures for twelve months. A medical board is not required if the convulsive disorder is well controlled.
- f. Friedreich's ataxia.
- g. Hepatolenticular degeneration.
- h. Migraine. Manifested by frequent incapacitating attacks or attacks that last for several consecutive days and unrelieved by treatment.
- i. Cerebrovascular disease. Manifest by neurologic symptoms, focal or general, degenerative neurological disorders. Manifest by neurologic symptoms, focal or general.
- j. Multiple sclerosis.
- k. Myelopathy transverse.
- l. Narcolepsy, cataplexy, and hypersomnolence.
- m. Paralysis, agitans.
- n. Peripheral nerve conditions.
  - (1) Neuralgia. When symptoms are severe, persistent, and not responsive to treatment.
  - (2) Neuritis. When manifested by more than moderate, permanent functional impairment.
- o. Syringomyelia.
- p. Vertigo. When refractory to treatment or resulting from neoplasm.
- q. General. Any other neurological condition, regardless of etiology, when after adequate treatment, there remain residuals, such as persistent severe headaches, convulsions not controlled by medications, weakness or paralysis of important muscle groups, deformity, incoordination, pain or sensory disturbance, disturbance loss of consciousness, speech or mental defects, or personality changes of such a degree as to definitely interfere with the performance of duty.
- r. Myasthenia graves.

16. Psychiatric Disorders. (See Chapter 5 Section B of this Manual concerning disposition.)

- a. Disorders with Psychotic Features. Recurrent psychotic episodes, existing symptoms or residuals thereof, or recent history of psychotic reaction sufficient to interfere with performance of duty or with social adjustment.
- b. Affective disorders; anxiety, post-traumatic stress disorder or somatoform disorders. Persistence or recurrence of symptoms sufficient to require treatment (medication, counseling, psychological or psychiatric therapy) for greater than twelve (12) months. Prophylactic treatment associated with significant medication side effects such as sedation, dizziness, or cognitive changes or requiring frequent follow-up that limit duty options is disqualifying. Prophylactic treatment with medication may continue indefinitely as long as the member remains asymptomatic following initial therapy. Any member requiring medication for any of the above disorders must be removed from aviation duty. (Incapacity of motivation or underlying personality traits or disorders will be processed administratively. See Military Separations, COMDTINST M1000.4 (series) for further guidance.)
- c. Mood disorders. Bipolar disorders or recurrent major depression do not require a six (6) month evaluation period prior to initiating a medical board. All other mood disorders associated with suicide attempt, untreated substance abuse, requiring hospitalization, or requiring treatment (including medication, counseling, psychological or psychiatric therapy) for more than twelve (12) months. Prophylactic treatment associated with significant side effects such as sedation, dizziness, or cognitive changes, or frequent follow-up that limit duty options is disqualifying. Prophylactic treatment with medication(s) may continue indefinitely as long as the member remains asymptomatic following initial therapy. Any member requiring medication for any of the above disorders must be removed from aviation duty. (Incapacity of motivation or underlying personality traits or disorders will be processed administratively. See Military Separations, COMDTINST M1000.4 (series) for further guidance.)
- d. Personality; sexual; factitious; psychoactive substance use disorders; personality trait(s); disorders of impulse control not elsewhere classified. These conditions may render an individual administratively unfit rather than unfit because of a physical impairment. Interference with performance of effective duty will be dealt with through appropriate administrative channels (see Chapter 5 Section B of this Manual).
- e. Adjustment Disorders. Transient, situational maladjustment due to acute or special stress does not render an individual unfit because of physical impairment. However, if these conditions are recurrent and interfere with military duty, are not amenable to treatment, or require prolonged treatment, administrative separation should be recommended (see Chapter 5 Section B of this Manual).
- f. Disorders usually evident in infancy, childhood, or adolescence, disorders of intelligence. These disorders, to include developmental disorders, may render an individual administratively unfit rather than unfit because of a physical impairment.

Anorexia Nervosa and Bulimia are processed through PDES, while the remaining are handled administratively, if the condition significantly impacts, or has the potential to significantly impact performance of duties (health, mission, and/or safety). Use of non-controlled medications such as Atomoxetine or Bupropion to treat, control, or improve performance for individuals diagnosed with Attention Deficit Disorder (either ADD or ADHD) may be allowed in individuals when a good prognosis is present. Individuals with Attention Deficit Disorder that significantly impacts performance despite treatment, or if treatment is refused or due to non-compliance, have a disqualifying condition and are processed administratively as per Military Separations, COMDTINST M1000.4 (series).

17. Dental. Diseases and abnormalities of the jaws or associated tissues when, following restorative surgery, there remain residual conditions that are incapacitating or interfere with the individual's satisfactory performance of military duty, or deformities that are disfiguring. Personnel must be in a Class 1 or Class 2 (see 4.C.3.c.(3)) dental status to execute sea duty or overseas duty orders. Prior service personnel must meet the enlistment dental standards contained in Section 3-D.
18. Blood and Blood-Forming Tissue Diseases. When response to therapy is unsatisfactory, or when therapy requires prolonged, intensive medical supervision.
  - a. Anemia.
  - b. Hemolytic disease, chronic and symptomatic.
  - c. Leukemia, chronic.
  - d. Polycythemia.
  - e. Purpura and other bleeding diseases. Any condition requiring long-term coumadin.
  - f. Thromboembolic disease.
  - g. Splenomegaly, chronic.
19. Systemic Diseases, General Defects, and Miscellaneous Conditions.
  - a. Systemic Diseases.
    - (1) Blastomycosis.
    - (2) Brucellosis. Chronic with substantiated recurring febrile episodes, severe fatigability, lassitude, depression, or general malaise.
    - (3) Leprosy. Any type.
    - (4) Porphyria Cutanea Tarda.
    - (5) Sarcoidosis. Progressive, with severe or multiple organ involvement and not responsive to therapy.
    - (6) Tuberculosis (TB).

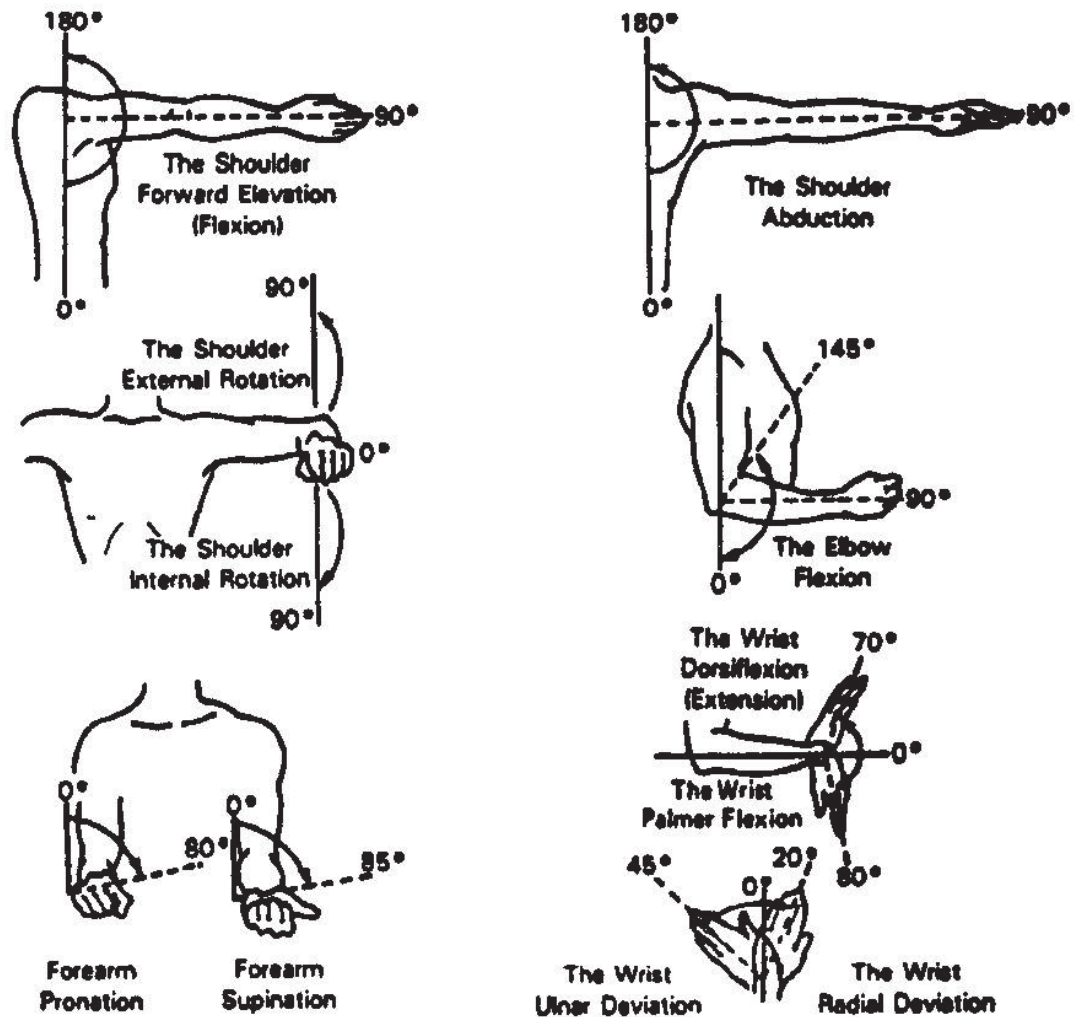


- (a) Meningitis, tuberculosis.
  - (b) Pulmonary TB, tuberculous empyema, and tuberculous pleurisy.
  - (c) TB of the male genitalia. Involvement of the prostate or seminal vesicles and other instances not corrected by surgical excision, or when residuals are more than minimal, or are symptomatic.
  - (d) TB of the female genitalia.
  - (e) TB of the kidney.
  - (f) TB of the larynx.
  - (g) TB of the lymph nodes, skin, bone, joints, eyes, intestines, and peritoneum or mesentery will be evaluated on an individual basis considering the associated involvement, residuals, and complications.
- (7) Symptomatic neurosyphilis. In any form.
- b. General Defects.
- (1) Visceral, abdominal, or cerebral allergy. Severe or not responsive to therapy.
  - (2) Cold injury. Evaluate on severity and extent of residuals, or loss of parts as outlined in Section 3-F-12.
- c. Miscellaneous Conditions or Circumstances.
- (1) Chronic Fatigue Syndrome, Fibromyalgia, and Myofascial Syndrome when not controlled by medication or with reliably diagnosed depression.
  - (2) The individual is precluded from a reasonable fulfillment of the purpose of employment in the military service.
  - (3) The individual's health or well-being would be compromised if allowed to remain in the military service.
  - (4) The individual's retention in the military service would prejudice the best interests of the Government.
  - (5) Required chronic and continuous DEA controlled (Class I-V) medications, such as Ritalin, Amphetamine, Cylert, Modafanil.
  - (6) Required chronic anti-coagulant, other than aspirin, such as Coumadin.
  - (7) Chronic (greater than 30 days per year) use of immunosuppressive medications including steroids.

20. Tumors and Malignant Diseases.

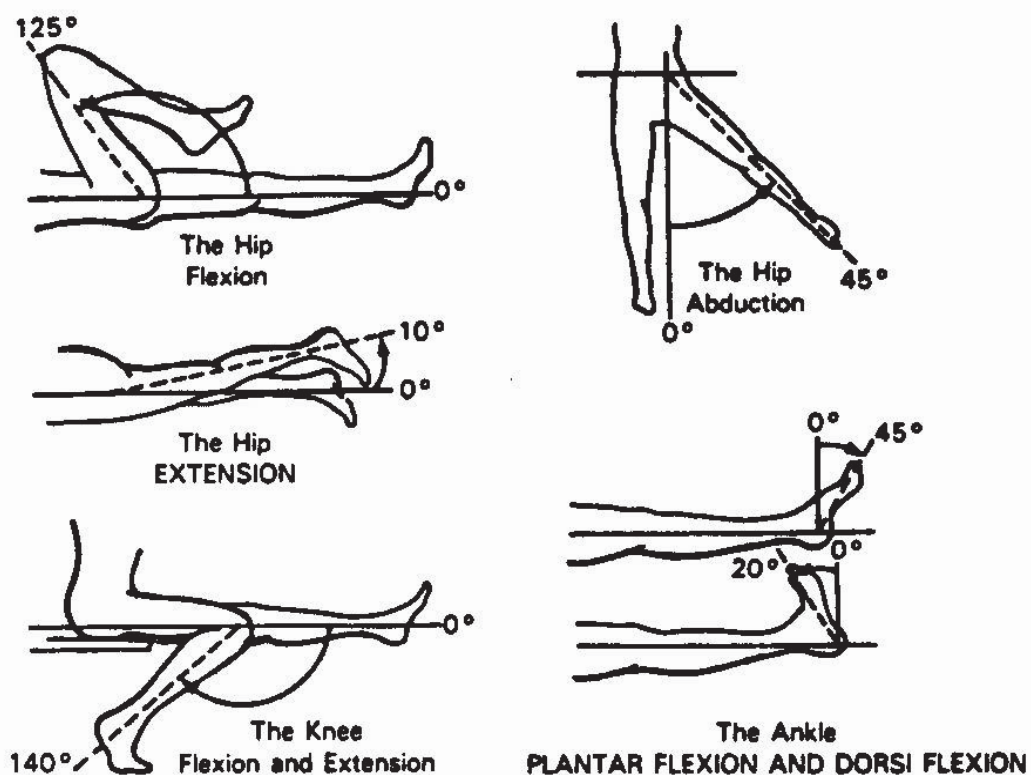
- a. Malignant Neoplasms. If they are unresponsive to therapy or when the residuals of treatment are in themselves disqualifying under other provisions of this section or in individuals on active duty when they preclude satisfactory performance of duty.
  - b. Neoplastic Conditions of Lymphoid and Blood Forming Tissues. Render an individual unfit for further military service.
  - c. Benign Neoplasms. Except as noted below, benign neoplasms are not generally a cause of unfitness unless not responding to treatment and/or with residual symptoms causing incapacitation or inability to perform required duties. Individuals who refuse treatment are unfit only if their condition precludes satisfactory performance of military duty. However, the following normally render the individual unfit for further military service:
    - (1) Ganglioneuroma.
    - (2) Meningeal fibroblastoma. When the brain is involved.
21. Sexually Transmitted Infection. Complications or residuals of such chronicity or degree of severity that the individual is incapable of performing useful duty.
22. Human Immunodeficiency Virus (HIV). CG personnel who demonstrate no evidence of unfitting conditions of immunologic deficiency, neurologic deficiency, and progressive clinical or laboratory abnormalities associated with HIV or AIDS-defining condition shall be retained in the service unless some other reason for separation exists.
23. Transplant recipient. Any organ or tissue except hair or skin.

**3-F — EXHIBIT 1**  
**MEASUREMENT OF ANKYLOSIS AND JOINT MOTION**  
**UPPER EXTREMITIES**



This Exhibit provides a standardized description of ankylosis and joint motion measurement of the upper extremities. The anatomical position is considered as 0° with two major exceptions: (1) in measuring shoulder rotation, the arm is abducted to 90° and the elbow is flexed to 90° so that the forearm reflects the midpoint (0°) between internal and external rotation of the shoulder; and (2) in measuring pronation and supination, with the arm next to the body and the elbow flexed to 90°, the forearm is in mid position (0°) between pronation and supination when the thumb is uppermost.

**3-F — EXHIBIT 2**  
**MEASUREMENT OF ANKYLOSIS AND JOINT MOTION**  
**LOWER EXTREMITIES**



This Exhibit provides a standardized description of ankylosis and joint motion measurement of the lower extremities. The anatomical position is considered as 0°.

G. Physical Standards for Aviation.

1. Physical standards for Aviation Personnel are located in the Coast Guard Aviation Medicine Manual, COMDTINST M6410.3 (series).



H. Physical Examinations and Standards for Diving Duty. To promote safety and to provide uniformity and completeness, a diving physical examination must be performed by a currently qualified Dive Medical Officer (DMO). Any health care provider can recommend to the command a limited duty status based upon medical illness or injury. An ill or injured diver may only be returned to diving duties by a qualified DMO.

1. Examinations.

- a. Candidates. Personnel whose duty exposes them to a hyperbaric environment must conform to the physical standards for diving duty. The Physical standards for diving duty are a combination of standards contained in section 3-D and the additional standards listed in this section. It is therefore critical that the HCP evaluating divers and candidates for diver training be familiar with these physical standards.
- b. Dive Physical Examinations. Dive physical examinations should be performed by a Medical Officer who has successfully completed the diving Medical Officer (DMO) course at the Naval Diving Salvage training Center (NDSTC). However, any credentialed CG HCP may perform a Dive Physical but final approval can only be made by review and countersignature of a qualified Dive Medical Officer (DMO).
- c. Frequency of examination. The diving physical is performed on candidates when applying for initial dive training. Subsequent examinations are performed on designated divers on birth date at ages 20, 25, 30, 35, 40, 45, 50, and annually thereafter, and in support of waiver requests when a diver's physical condition requires a determination of fitness for diving duty. All members on diving duty will have an annual periodic health assessment (PHA) to maintain diving duty qualification. This will include recommended preventive health examinations. For divers the annual PHA will include documentation of skin cancer screening. Additionally, all designated divers require an audiogram every 5 years. If at anytime a significant threshold shift is documented, follow up per OMSEP requirements outlined in Chapter 12, Section 7, of this Manual will be completed. When a members hearing falls outside the diving duty standards, a waiver is required.
- d. Documentation. A dive physical will consist of a completed Report of Medical History, Form DD-2807-1 and Report of Medical Examination, Form DD-2808. All applicants for initial and follow-on dive training must have a valid Diver-Buds Medical Screening Questionnaire, Form CG-6000-3 (formally known as Exhibit 8), completed and signed no later than 30 days prior to commencing training. This form serves as an interval medical history from the time the original dive physical was performed up to the member's training date as well as a medical screening for any missed or new condition that may be considered disqualifying. Any condition found to be disqualifying needs to be addressed prior to the member's transfer to dive

training. The U.S. Military Diving Medical Screening Questionnaire should be added to the member's medical record.

- e. Waivers. Waivers for initial application or continuance of duty may be requested if a disqualifying condition exists. The request is routed from the examining HCP to HSWL SC then on to a DMO. Initial applicant waivers must also be approved by NDSTC prior to the member commencing training. Appropriate documentation for the waiver request includes:
    - (1) A Chronological Record of Care, Form SF-600 prepared by the examining HCP requesting the waiver referencing the specific standard for which the member is not physically qualified, a clinical synopsis including history, focused examination, clinical course, appropriate ancillary studies, and appropriate specialty consultation, followed by a recommendation of "waiver recommended" or "waiver not recommended" with supporting rationale.
    - (2) Endorsement by the member's CO.
    - (3) Enclosure documentation of pertinent studies supporting the waiver or recommending disqualification.
    - (4) Specialty consult supporting the waiver or recommending disqualification.
  - f. Fitness for diving duty. Any credentialed CG health care provider can recommend to the command a limited duty status based upon medical illness or injury. An ill or injured diver may only be returned to diving duty by a qualified DMO.
2. Standards.
- a. Age Requirements. Candidates beyond the age of 35 shall not be considered for initial training in diving.
  - b. Ear, Nose and Throat. Chronic Eustachian tube dysfunction or inability to equalize middle ear pressure is disqualifying. Any persistent vertigo, dysequilibrium, or imbalance with inner ear origin is disqualifying. Maxillofacial or crainiofacial abnormalities precluding the comfortable use of diving headgear, mouthpiece, or regulator is disqualifying. Hearing must meet standards for initial acceptance for active duty. Hearing standards are:
    - (1) 1000Hz -30dB, 2000Hz-35dB, 3000Hz- 45dB, 4000Hz-55dB
    - (2) Results greater than the above listed dB require a waiver.  
Designated divers with full recovery from either tympanic membrane perforation or acute sinusitis may be returned to diving duties after evaluation by a DMO.



- c. Eyes and Vision. All divers must have corrected visual acuity not worse than 20/25 in one eye. For Second Class Divers (DV2) assigned to diving duty and Diving Medical Technicians (DMT): 20/20 in each eye. History of refractive corneal surgery is not considered disqualifying. However, candidates must wait 3 months following their most recent surgery (PRK or LASIK), have satisfactory improvement in visual acuity, and be fully recovered from any surgical procedure. A designated diver must wait 1 month post-LASIK/PRK and be fully recovered from any surgical procedure with satisfactory improvement in their visual acuity prior to resumption of diving. Corneal complications lasting 6 months or longer after cessation of hard contact lens wear is disqualifying. Lack of adequate color vision is disqualifying. Waivers will be considered on a case-by-case basis.
- d. Pulmonary. History of spontaneous pneumothorax is disqualifying. Traumatic Pneumothorax (other than caused by a diving-related pulmonary barotrauma) is disqualifying. A waiver request will be considered for a candidate or designated diver after a period of at least 6 months and must include: a normal pulmonary function test, standard, non-contrast chest CT, favorable recommendation from a pulmonologist, and final evaluation and approval by a DMO. Chronic obstructive or restrictive pulmonary disease is disqualifying. Candidates and designated divers undergoing drug therapy for a positive Tuberculin Skin Test (TST) must complete a full course of chemoprophylaxis prior to the start of diver training or reinstatement to diving duty. Designated divers who experience mediastinal or subcutaneous emphysema resulting from a dive are restricted from diving duty for 1 month. They may be returned to diving duty following completion of the waiver process if the diver is asymptomatic and is determined to have a normal, standard, non-contrast chest CT. A history of pulmonary barotrauma in a diver candidate is disqualifying. Designated divers who experience a second pulmonary barotrauma are considered permanently disqualified for diving duty.
- e. Skin and Lymphatics. Skin cancer or severe chronic or recurrent skin conditions exacerbated by sun exposure, diving, the hyperbaric environment or the wearing of occlusive attire (e.g., a wetsuit) are disqualifying.
- f. Gastrointestinal. Gastroesophageal reflux disease that interferes with or is aggravated by diving duty is considered disqualifying. Designated divers with full recovery from acute infections of abdominal organs may be returned to diving duties at the discretion of a DMO. Designated divers with a history of symptomatic or bleeding hemorrhoids may be returned to diving duties at the discretion of a DMO. Designated divers with a full recovery from abdominal surgery (including hernia repair) may apply for a waiver after 3 months of post-operative recovery.
- g. Genitourinary. Invasive cancer is disqualifying. Designated divers with a full recovery from acute infections of genitourinary organs may be returned to diving duties at the discretion of a DMO. Pregnancy is disqualifying. Post-

partum members are eligible for diving duties 6 months after delivery. Return to earlier duty requires a waiver.

- h. Dental. All divers must be dental class 1 or 2. Fixed active orthodontic appliances require a waiver from PSC-opm or epm (fixed retainers are exempt).
- i. Musculoskeletal. Any musculoskeletal condition that is chronic or recurrent which predisposes to diving injury, limits performance of diving duties, or may confuse the diagnosis of a diving injury is disqualifying. Any fracture (including stress fractures) is disqualifying if it is less than 3 months post injury, and if there are any residual symptoms. Designated divers with full recovery from uncomplicated fractures with no residual pain may be reinstated at the discretion of a DMO. Bone or joint surgery is disqualifying if it is within 6 months and there is any significant or functional residual symptoms. Retained hardware is not disqualifying unless it results in limited range of motion.
- j. Psychiatric. The special nature of diving duties requires a careful appraisal of the candidate's emotional, temperamental, and intellectual fitness. Past or recurrent symptoms of neuropsychiatric disorder or organic disease of the nervous system are disqualifying. No individual with a history of personality disorder shall be accepted. Neurotic trends, emotional immaturity or instability and antisocial traits, if of sufficient degree to militate against satisfactory adjustment are disqualifying. Stammering or other speech impediment that might become manifest under excitement is disqualifying. Treatment of any emotional, psychological, behavioral, or mental dysfunction should be completed and the diver asymptomatic before return to duty is supportable by a waiver. No time limit is required post treatment but the recommendation of the attending mental health professional of fitness for full duty and concurrent assessment of fitness for duty by a DMO is sufficient to begin the waiver process. Use of psychotropic medication for any purpose including those that are not psychiatric such as smoking, migraine headaches, pain syndromes, is not prohibited with diving duty but must be approved by a DMO. Diagnosis of alcohol dependence will result in disqualification until successful completion of a treatment program and a 1-year aftercare program. A diagnosis of alcohol abuse or alcohol incident will result in disqualification from diving duty until all recommended treatment courses or course mandated by the members CO have been completed.
- k. Neurological. Idiopathic seizures are disqualifying except for febrile convulsions before age 5. Two years of non-treated seizure-free time is necessary before a waiver will be considered. Seizures with known cause may be returned earlier to duty by waiver. Syncope, if recurrent, unexplained, or not responding to treatment is disqualifying. All dive physicals require documentation of a full neurologic examination and tympanic membrane

mobility in blocks 44 and 72b respectively on the Report of Medical Examination, Form DD-2808.

- l. Decompression Sickness / Arterial Gas Embolism. In a diving duty candidate, any prior history of decompression sickness or arterial gas embolism is disqualifying and requires a waiver. Designated divers diagnosed with any decompression sickness (including symptoms of joint pain or skin changes) shall: have an entry made in their medical record describing the events and treatment of the injury, signed by the attending DMO and be evaluated by a cardiologist for presence of a patent foramen ovale (PFO) with results documented in health record. Designated divers diagnosed with AGE or DCS type II presenting with neurological, pulmonary, or shock symptoms will be disqualified for diving duty pending work-up and evaluation by a DMO and waiver approval.
- m. Required Labs and Special Studies. For candidates applying for initial dive duty and for designated diver physical examinations the following labs and special studies are required in support of the Report of Medical Examination, Form DD-2808: Serology; CBC with Diff; Lipid panel; Fasting blood glucose, HIV, Urinalysis; Hepatitis C screening; G6PD; Sickle Cell; Blood type; Chest x-ray (PA and lateral); Audiogram; EKG; and PPD. In addition to the Immunization and Chemoprophylaxis (Joint Publication), COMDTINST M6230.4 (series) requirements, all diver candidates and designated divers must be immunized against both Hepatitis A and B. Diver candidates must have two doses of Hepatitis A immunization and at least the first two of three doses of Hepatitis B immunization prior to the start of diver training.
- n. Miscellaneous. The use of Bupropion for tobacco cessation is not disqualifying for diving duty, but requires approval by a DMO. Qualified divers or dive candidates are not fit for diving duty when they are taking INH for positive TST testing. Waiver must be obtained to return to diving duty.

